

Private Health Insurance and Medical Care

Conference Papers



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SOCIAL SECURITY ADMINISTRATION

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Foreword

THE INCREASING cost of health care, together with growing public awareness of the potential benefits of modern medicine and the importance of access to such care, has stimulated a fundamental review of the current organization of health services and their financing. Among the groups with a major concern and a major potential part to play are the private health insurance agencies.

To explore both problems and potentials, a National Conference on Private Health Insurance was sponsored by the U.S. Department of Health, Education, and Welfare, and organized by the Social Security Administration. The Conference was held in Washington, D.C., September 27 and 28, 1967.

Sixty leaders of major private health insurance organizations, purchasers of health insurance, providers of health care, and State regulators of health insurance were called upon by Secretary of Health, Education, and Welfare John W. Gardner "to explore ways of broadening the coverage of private health insurance plans to include more alternatives to hospital care and to suggest ideas for model State laws to encourage or require comprehensive health insurance coverage." A summary report on the Conference by the Commissioner of Social Security has been issued and is available from the Bureau of Health Insurance.

The first four papers in this volume were prepared as background for discussion at the Conference. All offer new data or groundbreaking approaches to the problems under consideration. They represent the authors' opinions rather than Conference consensus. The fifth paper is the closing address of the Under Secretary of Health, Education, and Welfare.

Further conferences and discussions of alternative ways of financing health care services are planned or in process in many parts of the country. We believe the papers presented here will be of use to those directly engaged in such discussions and of interest to all who are concerned with the adequacy and availability of health care in this country.

IDA C. MERRIAM,

Assistant Commissioner for Research and Statistics.

MARCH 1968.

Joseph W. Ehrenreich

1

Creating Competition in the Health-Care Industry: Possible Impacts of Major Group Purchasers on Costs and Quality of Health Care

AMONG THE THOUSANDS of studies prepared in recent years on the health-care industry in the United States, there are virtually none concerning the potential effects of major group purchasers upon the system. This is strange, in that all the other participants in the industry have been reported upon in exhaustive detail. The providers of care, the so-called third parties, and the governments have been studied both in general terms and in great detail. However, the major group purchasers—the single largest source of the funds that flow into the system—have received scant attention.

Accordingly, I was most pleased when the Department of Health, Education, and Welfare asked me to prepare a background paper for the National Conference on Private Health Insurance on the question of how management and labor might act to restrain the soaring prices of health services while their quality was at least maintained. The Medical Care Price Index, based on 1957 to 1959 as 100, was 122.3 in 1965, 127.7 in 1966, and up to 135.7 by May of this year. In the last 12 months alone, it has risen almost 7½ percent.

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It is always stimulating to be connected with a pioneering effort, and that is what this paper is. It is not designed to be comprehensive, or convincing, or in any way conclusive. It is rather designed to expand understanding, to present some possibly new views, and to be a basis for discussion, argument, and dialogue. From these and from the refinement and extension of this work, it is hoped that some advances in our Nation's capacity to cope with the problems of the health-care market may ultimately result.

While, as usual, the author of this paper must take full blame for all errors and inanities, I have been uniquely fortunate in the advice I have had. In order that the paper not be limited by my own ideas and prejudices, distinguished Los Angeles representatives of management and labor were invited to discussion meetings in which many of the thoughts herein presented were developed. As a measure of the tremendous interest and concern with which such people view the health-price problem, it is noteworthy that of 13 people invited, 11 attended or sent alternates. The 12th, a union executive, had to cancel at the last minute because of a strike problem; the 13th, an insurance-company official, could not attend because of a death in his family.

We were most privileged to be able to draw upon the experience and thoughts of the following men, although none of them should be considered as necessarily endorsing this report: Cass D. Alvin, education coordinator, United Steelworkers of America; Wallace J. Andrews, consultant, Merchants and Manufacturers Association; Charles Boren, executive vice president, Association of Motion Picture and Television Producers, Inc.; John Despol, representative, United Steelworkers of America; Anthony M. Frank, president, State Mutual Savings and Loan Association; Daniel Johnston, Daniel Johnston and Associates; Harold Klein, administrator, Food, Health and Welfare Fund, Retail Clerks Union; Irvin Mazzei, president, Los Angeles County Federation of Labor; Lawrence A. Peifer, labor relations associate, Ford Employers Council, Inc.; and Harry Winston, manager, Industrial Relations Branch, Lockheed-California Co. Particular appreciation is due Dean Robert Dockson and Professor Donald E. Yett for their constructive suggestions; to Max Fine of the U.S. Department of Health, Education, and Welfare for his sage advice and help; and to Robert Sigmond, executive director, Hospital Planning Association of Allegheny County, for his incisive comments.

The literature abounds with history, data, and proposals about the problems of health-care costs and their quality—what the problems are, their causes, and their remedies. Excellent materials are available, particularly the books *Bargaining for Health* by Munts,¹ *Health Plans*

¹ Raymond Munts, *Bargaining for Health* (Madison: University of Wisconsin Press, 1967).

and *Collective Bargaining* by Garbarino,² *How to Get the Most Out of Medical and Hospital Benefit Plans* by Brecher and Brecher,³ Tilove's article "Pensions, Health, and Welfare Plans,"⁴ and the many splendid papers prepared for June's National Conference on Medical Costs.⁵ It cannot really be useful to restate these or even to add more of the same. However, there is a dearth of material regarding the roles that management and/or labor—the major group-health-care purchasers—play or can play in these problem areas. There are some materials describing and analyzing what they are doing in health, but, except for some material in the book by Brecher and Brecher, one looks in vain for any analysis of group purchasers' interests and attitudes toward health care, their role perception, their options for action and policies, or their view of where their responsibilities begin and end.

Accordingly, it is the purpose of this paper to try to conceptualize and categorize how the major group purchasers do and can influence the costs and quality of health care. This paper will then attempt to suggest deficiencies in the ability of the current institutional organization to solve the big problems, and indicate possible revision that might make it more effective.

Many of the ideas that have been expressed over the years for expanding the supply of health-care providers, for reducing demand, or for introducing controls over the noncompetitive aspects of the industry have been ineffective, in my opinion, for two interrelated reasons. First, the ideas were just that—ideas. They might be considered as interesting hypotheses, based largely upon faith or judgment or prejudice. Many have plausible rationales, but, fraught as they are with implications for disruption of the accustomed ways and for acrimony with established institutions, they do not have an adequately hard, factual basis for activation. Plausibility is not enough. There is always difficulty, and rightfully so, in changing major social policies or programs without strong evidence that the changes will, in fact, have the desired results.

The related reason that the ideas have had tough sledding is that, in addition to lacking a firm intellectual basis, they have lacked the support of any significant power group. The providers of medical care have generally opposed significant changes through their organized associations, the third parties have been relatively passive and divided,

² Joseph W. Garbarino, *Health Plans and Collective Bargaining* (Berkeley: University of California Press, 1960).

³ Ruth Brecher and Edward Brecher, *How to Get the Most Out of Medical and Hospital Benefit Plans* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1961).

⁴ Robert Tilove, "Pensions, Health, and Welfare Plans," in Lloyd Ulman (ed.), *Challenge to Collective Bargaining* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1967).

⁵ Washington, D.C., June 27–28, 1967. See *Report of the National Conference on Medical Costs* (Washington: U.S. Government Printing Office, 1968).

and the individual consumers—the actual payors of the rising health costs—are unorganized and not fully cognizant of what has been happening to them.

Management and labor, working together in some instances and separately in others, have been the largest organized payors of health costs, either through payment of premiums or through direct payments to health-care providers. The Southern Pacific Railroad Co. established its still-existent medical-care prepayment system in 1868; the first national union health program was set up in 1877 by the Granite Cutters' Union. Now, there are thousands of different plans. It is estimated that two-thirds of the civilian population of the country are covered by a health plan purchased by or through a management and/or labor group. Yet the effects of these on restraining general health-care costs are probably quite negligible.

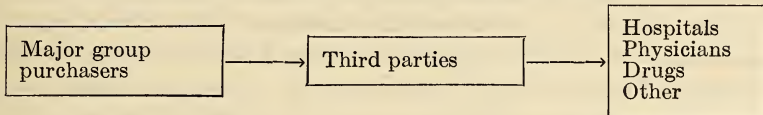
When management and labor reach agreement in their negotiations about health care, then they may bargain with third parties for the best buy. But they then are bargaining with the wrong group. The bargaining, at some point, has to be with the providers of health care. The ability of our free enterprise system to regulate economic forces through competition needs, among others, three conditions to enable it to work: There has to be a mechanism for dialog between the buyers and the sellers for bargaining to occur, there has to be knowledge on the part of the buyers, and there must be alternatives so that each side has bargaining power. As I see it, these do not exist to any adequate extent. For this, as well as other reasons, management and labor, despite their thousands of individual plans, have failed, together or separately, to correct the conditions that have led to the soaring costs.

Since management and labor, as the major purchasers of group coverages, are the natural choice to act for the consumer as a power force in opposition to the vendors' force, and since they do have economic as well as humanitarian motives for obtaining the best medical care for their people at reasonable cost, it seems appropriate to consider how they might be a more effective force in the health-care market. This is a particularly urgent task, because what choices are there? Who else will represent the consumer—the immediate victim of the cost-spiraling? Ultimately, of course, the entire economic system is the victim. If management and labor fail this challenge, if third parties do not radically revise their orientations, the Federal Government may have to step in as the consumers' representative. There is no other group existent that can exert the types of pressures that are necessary if health prices are to be restrained.

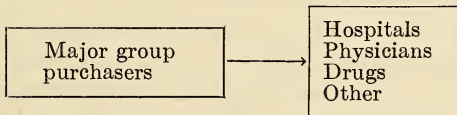
Consequently, this paper will focus on the roles that major group purchasers might play in regard to this national problem. It is based on several premises: First, that health-care prices will continue to rise

inordinately unless something new happens; second, that as prices rise, management and labor will become increasingly concerned and will examine the problem more deeply and become more knowledgeable and sophisticated; third, that when they do so they will move toward constraining measures such as those that follow. Analysis of their possible actions is built on two simple models of the market as it exists:

MODEL A.—*A three-segment model, in which the major group purchasers buy coverage from a third party, who in turn pays the vendors*



MODEL B.—*A two-segment model in which the first parties deal directly with the second parties*



In the following sections, this paper considers each of these models to explore the different strategies they afford the major group purchasers. In the final portion, there are some suggestions regarding the implementation of these strategies and ideas through institutional modifications in the health industry and through experimental research.

Impacts Involving Third Parties—Model A

One pattern of involvement of group purchasers in the task of controlling health-care costs and maintaining quality is through the third parties, who so often serve as intermediaries between the purchasers and providers of health care. Despite the fact that the third parties are themselves victims of increasing prices, and despite their occasionally serious losses due to unexpectedly high claim experience and their own frustration at their inability to contain the health-cost inflation, third parties remain the immediate point of contact of most group purchasers with the health-care system. This seems particularly curious. On the one hand, the Blue Cross and Blue Shield plans are closely affiliated, historically and in terms of current board memberships, with the principal vendors—physicians and hospitals; and the private insurance companies are mainly in the business of risk control. Neither group has, in the past, considered the sustained, hard-nosed pursuit of lower health costs as one of its prime functions. This is not

to say that they have been indifferent, but rather that they have not seen their role as one of vigorous bargainer with vendors on the consumers' behalf. On the other hand, their group-purchaser clients, which include some of the most rational, sophisticated, and economically powerful organizations in the country, have diffused their bargaining power in the health area by turning this matter over to the third parties.

As the principal payors of hospital and physician bills, the private insurance companies and the Blues have frequently been criticized for not exercising more of an influence in controlling health costs. Some insurance companies and some Blue Cross and Blue Shield plans, in some ways, have tried to keep costs down. Careful review of claims for surgical fees, followup discussions with physicians whose charges were considerably out of line and with local medical societies, direct and indirect involvement with hospital boards of directors have all been tried by some companies. The effects are not measurable, but obviously have not been adequate. Several Blue Cross plans have tried to stimulate efficiencies in hospital operations through incentive provisions in proposed reimbursement formulas and through suasive processes. Hospitals have, by and large, successfully resisted these attempts. Blue Shield plans have been somewhat more effective in helping to establish preset medical fees for low income subscribers.

However, once this is said, it is clear that still more needs to be done. More active programs of restraint on the part of individual third-party organizations would be very costly, and their success would be uncertain even in the short run. In the longer run, if a few such organizations were to initiate a program of restraint, their extra costs and possibly worsened relations with the medical profession and with hospitals would soon put them in a competitively untenable position. This is in the sense that if a few companies were to charge a price adequate to cover their costs, their customers would shift to other companies. It does not follow that if all the third parties acted together the same result would occur. But stimulation by an outside consumer force might lead to a greater willingness on their part to incur these economic and political costs. An expansion on this thought appears later.

What, then, can major group purchasers do to control the costs and quality of medical care through third parties? From the viewpoint of the public, most of whom pay for their health care through these third parties, the price of care consists of two sets of costs: the internal costs (including any profits) of the financial intermediaries and the prices charged by the providers of health care. It seems to me that the major group purchasers can, in the three-segment model, influence

costs in both these areas through impacts on product specifications, by consumer education, through influence on third-party administrative costs, and by direct impact on medical and hospital prices.

PRODUCT SPECIFICATIONS

It has been pointed out by many observers that socially noneconomic health services are often provided or prescribed because this is advantageous to an individual patient. One commonly mentioned example is the utilization of hospital facilities for simple procedures that can be done in an office or a convalescent home, solely because the former are covered by a hospitalization policy while the latter are not. It has also been pointed out that the huge variety of health plans that are available makes it impossible for most purchasers to evaluate plans comparatively because of differences in coverages, levels of benefits, and claim-payment policies. It seems to me that major group purchasers can do something about each of these.

Comprehensiveness of products.—Group purchasers can push for plans that are more comprehensive. (I differ from those who say that completely comprehensive prepaid plans are needed now. Such plans—at this time—would lead to abrupt increases in the demand for additional services and, with the well-known shortages in the supply of health resources, further price increases.) More comprehensiveness is needed to avoid the common misallocations of scarce resources occasioned by today's usual restrictions. There are, admittedly, risks of abuse in any steps of this type, but how can progress be made without risk, and how can management policies be formulated to reduce these risks until actual experience is obtained?

Standardization of products.—Group purchasers can take more initiative in developing detailed specifications of what they want in a prepaid health plan, be it of an indemnity or service type. Some large groups have been conspicuously successful in doing this, usually because of union pressures, exercised through the collective-bargaining process. The Steelworkers, Auto Workers, and Mine Workers have used this approach on a national basis for almost two decades; the Clothing Workers for even longer. Some local collective-bargaining units also have initiated similar programs. But, in general, the group purchaser still relies upon the third parties for the development of package plans and for proposals. Group purchasers, in so doing, invite confusion and nonrationality because they cannot usually make knowledgeable cost-benefit analyses of the different proposals. It would be much simpler to specify what is wanted and then obtain bids from several third parties. This would tend to force the third parties to

compete on economic grounds, with all the concomitant pressures for cost control and more efficiency.

A big obstacle to this approach occurs, however, in the many cases in which the collective-bargaining procedures that lead to the group purchase result in an agreement on health-coverage expenditures rather than on types and levels of benefits, or in an agreement to give the coverage to a specified third party. (The Steelworkers' one-time preference for having Blue Cross and Blue Shield provide their health insurance is an example of the latter.) In either of these situations, the advantages of competitive bidding are lost. Accordingly, it would be well for labor and management to bargain for health benefits rather than for the amount of money to go into this fringe benefit. I realize this is a much-debated subject and that many arguments can be made for labor-management agreements on health-premium dollars rather than benefit levels, but I suggest that in the interest of injecting the advantages of free competition into at least part of the health industry, emphasis should first be on benefits. Obviously, it would be completely unrealistic to bargain on benefits without some consideration of the price levels involved, but this is a solvable problem, since the number of consulting actuarial firms could be expected to increase to provide this service as it is needed.

CONSUMER EDUCATION

It would be of little avail for sophisticated group purchasers and third parties to develop economic approaches to health care if the consumer remained naive about them. If the consumer does not recognize the value of patronizing accredited hospitals or, most important, does not realize that he is affected by the rising costs of health care even if he does not get ill, and even if his employer pays the entire health-care premium, then, in the long run, group purchasers will continue to face an uphill battle in trying to reduce costs and maintain quality.

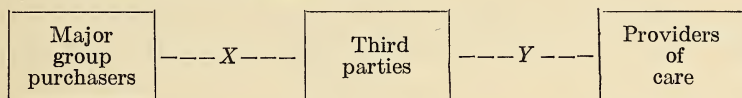
The economics and sociology of health care are quite complicated. In our democratic society, public awareness and the resultant support or protest ultimately come to be reflected in private and public policies. For these to be sound, the public's awareness must hopefully be based on fact. In our case, the development and acceptance of policies to control costs will benefit from broader consumer understanding. The group purchasers—union and management—can help accomplish this by programs to teach the consumer such things as how much health care costs, who is paying for it, why there are certain restrictions in coverages that are necessary, alternatives that may have been possible and why they were not taken, the consequences to costs of claim abuses, the pros and cons of group practice and solo practice among physi-

cians, the proper role of paramedical personnel, and the proper role of extended-care facilities other than hospitals.

Factors that are generally considered in attempts to increase the efficiency of an institutional system include the possibilities of effecting more economies of scale, effecting economies through division of labor, building-in automatic restraints of cost escalations or inefficiencies, and shifting some functions to lower-cost alternatives. Persuasive cases can be made for how these suggestions would help to realize these possibilities, not only as they apply to the insurance carriers but also as they apply to the providers of health care themselves.

THIRD-PARTY MANAGEMENT POLICIES

As large-scale customers deciding on the expenditures of hundreds of millions of dollars for health insurance each year, the major group purchasers can have a great deal of influence on the management policies of third-party intermediaries. They have had, in many instances, but an area of potential influence in which little has been done is that of the relationship between the third parties and the providers of medical care—sphere *Y* as diagramed below:



Applications of influence have been primarily in sphere *X*. In the section that follows, the *X* sphere will be commented upon, but it is also suggested that sphere *Y* offers significant opportunities for group purchasers.

Third-party costs (sphere X).—Conceivably, the group purchasers could radically affect third parties' operations. Over the years, they have been instrumental in, among other things, stimulating dramatic reductions in retention rates. According to Louis S. Reed, in 1948, private health insurance organizations (including Blue Cross-Blue Shield plans, insurance companies, and independent plans such as community-consumer programs and employer-employee-union programs) retained 29.7 percent of subscription or premium income. In 1964, the comparable figure was 12.8 percent. Included in these figures are the retention rates for individual as well as group coverages, and the differences are interesting. In insurance companies, the retention rates on individual policies decreased from 62 percent to 45 percent between 1948 and 1964, or more than a fourth. During the same period, the group insurance rates dropped from 30 percent to 8 percent, or almost three-quarters.⁶

⁶ Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1965," *Social Security Bulletin*, XXIX (November 1966), 12.

It is impossible to attribute any specific share of this dramatic reduction to the direct influence of the group purchasers, because other factors also were at play, but it seems clear that they have been responsible for a significant portion.

Major group purchasers can go further in stimulating additional reductions in the operating and marketing costs of third parties. They can do this in a generalized fashion through an emphasis on more comprehensive plans and more standardized packages, as mentioned earlier. Similarly, a better-informed employee body would tend to enable third parties to operate with lower costs because of fewer abuses and more individual-consumer bargaining with vendors. More specifically, and in addition, sample screening of claims by the major group purchasers to nip abusers and abuses in the bud, periodic claim reports and analyses, efforts directed toward reducing the hundreds of different claim-reporting forms so that providers could routinize their completion, and other similar steps would have some, although probably relatively minor, effects on costs. A more important step would be to rationalize the commissions paid for group business. Under State laws based upon antidiscriminatory concepts, a commission has to be paid by insurance companies for group business. Accordingly, despite the fact that salaried employees frequently do all the necessary work, a commission expense must be incurred. Some individuals frequently reap handsome rewards for doing virtually nothing. Group purchasers would seem to have an opportunity to help eliminate this economically unnecessary requirement by aggressive action at the State legislative level.

Furthermore, the whole question of an indemnity system of insurance is something for group purchasers to consider. There is a large body of informed opinion that believes that, in Raymond Munts' words, "indemnity insurance is part of the problem rather than part of the solution."⁷ For this reason, many purchasers have sought service-benefit coverages, and indemnity-type carriers have shifted some coverages—hospital room charges and major medical provisions, for instance—to a service basis. Consequently, if further investigation proves that an indemnity system of coverage does, in fact, tend to promote higher factor prices and does not deter inferior care, then it would seem reasonable for the major group purchasers to use their power to do away with such plans.

In this connection, an interesting collaborative idea is being explored by a number of major life insurance companies and the Harvard Medical School. Through an exchange of technical assistance and guidance, the insurance carriers and the school are looking toward

⁷ Munts, *op. cit.*, p. 129.

ways whereby, in the Boston area, the groups of insureds will have the choice of obtaining service benefits from a division of the medical school. Similar explorations are now current with other carriers and will certainly be watched closely by other health insurers as well as by hospital administrators and the medical fraternity.

Factor prices (sphere Y).—The curious structure so often found whereby strong group purchasers turn over their buying power to third parties, who in turn are less than effective in controlling either vendor prices or the quality of care, has been remarked upon previously. When the third party expends the group purchasers' funds for health care, what are his responsibilities? What should they be? These are questions that need to be asked and seriously considered, but that are not within the scope of this paper.

Our question is, can group purchasers influence third parties to exercise more vigor in their vendor relationships? It seems to me the answer to this has to be, Yes, of course large purchasers can wield great influence with sellers. However, there are three elements to this: One, the purchasers must act with unified purpose; two, the third parties must reorient their thinking to accept the control activity as one of their primary roles; and, three, the third parties must develop and implement appropriate policies. In the final section, on suggestions, this theme will be expanded.

Impacts Directly on Providers—Model B

Up to now, this paper has consisted of reflections on how major group purchasers might exercise their considerable influence in stimulating third parties to control costs and prices. Now we turn to consideration of how this influence might be brought to bear directly upon health-care prices—how group purchasers can affect the charges made by the providers of health care.

DIRECT OPERATION OF HEALTH-CARE ORGANIZATIONS

There are two strategies that major group purchasers could, and have, pursued: one, the direct approach, in which they would support their own facilities, paying salaries to the nonmedical staff and reimbursing the medical staff on some negotiated basis rather than by the usual, unilaterally established fee for service. Examples of successful ventures of this sort are the Southern Pacific Employees Hospital Association, the Kaiser Foundation Health Plan, the United Mine Workers' program, and the International Ladies' Garment Workers' Union health centers. These programs are each quite different in scope and approach, but are similar in giving their sponsors more

administrative control over the costs and quality of health care. This, in turn, is reflected in lower costs and prices.

This is not an easy way to proceed, as evidenced by the rough sailing in one way or another that each plan has had. The hostility of organized medicine, the lack of awareness or appreciation of the individuals in the plans, the conflicting objectives of union politics, the comprehensiveness of care, individuals' wants, and adequate funding have all been problems. Yet the fact remains that, through these programs, expenses were constrained, quality care could be sought, and the defenders of the status quo could be shaken and induced to reexamine their position. They were, to some extent, influenced to be competitive either through price-increase restrictions or through the development of new, countering institutions. An interesting one that developed to counter expansion of the Kaiser Plan is the San Joaquin Foundation for Medical Care, which was established by the San Joaquin County Medical Society in California to provide care at predetermined fees, using third-party mechanisms.

Prepayment medical centers.—Given the high interest in health care among many giant unions and many giant business firms, it is conceivable that, if other methods failed to control costs, then these groups could combine to create a national chain of prepayment group-practice centers, with hospital, convalescent-home, and nursing-home affiliates. If these centers were open to the community, they would certainly provide a potent competitive force in the marketplace—one that existing providers could not ignore in setting their fees.

Self-insurance indemnity programs.—It may seem a natural corollary to this "do it yourself" approach for major group purchasers to expand their self-insurance indemnity programs. Self-insurance, combined with purchased stop-loss coverage for extraordinarily high claim experience, would seem a likely way to reduce the prices of health care. Potential savings on a private carrier's marketing costs, mandatory commissions, contingent reserves, possibly, and on State premium taxes have been estimated by the Food Employers Council of Southern California at about 10 percent. Quite a few employers and union groups have moved in this direction.

It is not clear to me, however, that these savings are permanent or that they compensate in the long run for lost opportunities to achieve economies of scale through specialization of function. There is also a problem, in self-insured group plans, concerning the people leaving the group. With a private carrier, they can ordinarily convert their group certificate into an individual policy, but the self-insured plans usually cannot do this. Accordingly, I wonder under what conditions a self-insured indemnity plan is really more effective; I could

not find any definitive analysis of this question. This seems a worthy subject for further study, with results that would be useful to both major group purchasers and to private carriers.

The health-insurance industry, perhaps more now than ever in the past, is competing in a market where the ground rules and even, to some extent, the name of the game are rapidly changing. Union pressures for service-type benefits, new health-care alternatives and combinations of alternatives, Medicare and Medicaid, shifting medical attitudes, Federal concern about costs, and the as yet unknown effects of the Comprehensive Health Planning and Public Health Amendments of 1966 (Public Law 89-749) make the role of the private carrier a particularly difficult one and call for new adaptations and philosophies.

MANAGEMENT-LABOR COALITION

A strategy open to management-labor groups as an alternative to actual operation of health-care organizations is the indirect one whereby the potential power of major group purchasers to establish their own health-care organizations is assembled and focused in some suitable organization and maintained as a deterrent to capricious increases in prices and careless administrative practices.

A point that cannot be overlooked in any consideration of how major group purchasers can affect providers directly is the fact that, to some extent, major group purchasers run the private hospitals. The boards of directors of these hospitals are largely composed of businessmen, with an increasing number of union leaders joining them. What often seems to be needed, however, is more recognition by these men of the intermingling nature of their two roles.

Summary and Suggestions

Up to this point, this paper has briefly discussed various ideas that major group purchasers might employ to restrain increases in health-care costs and encourage quality care. Actually, of course, these are more than ideas; most, if not all of them, are being practiced by one or more major group purchasers. Yet prices continue to soar.

Does this mean that the strategies are nonvalid? No, I don't believe so. Probably, without them, prices would have gone even higher. It does seem to indicate that a more massive, vigorous application of the strategies is needed to counteract the basic cause of the extraordinary inflation we are experiencing in the health field. The fragmented, partial applications that we have are not enough.

Some stronger force is necessary to negotiate effectively with the providers in the health field. It seems likely that unless some such force

develops, the Government will initiate some control devices. It has become a generally accepted function of government to concern itself with policies to control general inflation; it is simple to expand this perspective to include such a special problem as that of health care.

Reading and reflecting on these issues as summarized in the preceding pages have brought me tentatively to the following beliefs:

First, the rising prices of health care stem, to a large extent, from the noncompetitive markets in which physicians and hospitals operate. This is reflected in the physician's almost unilateral control of his fees and in the hospitals' ability to continue to operate with little regard for economic rationality.

Second, in contrast with the situation in other markets, the bargaining power of the ultimate health-care consumer and his opportunity to shift from higher-priced sellers to more economical ones are very limited.

Third, if the healthful effects of a competitive market are to be introduced in the medical marketplace, a continuing countervailing force that does not now exist will be needed.

Fourth, hospitals are unlikely, of their own volition, to relinquish some of their socially dysfunctional high levels of autonomy and independence.

Fifth, the labor and/or management groups have one of the biggest stakes in the game, but they have been relatively quiet for a long time. As prices continue to go up and as the Government intensifies its focus on the problem, these groups will be increasingly heard from in one or more of the ways described above.

Sixth, there is no shortage of ideas about what should be done. There is, however, a shortage of well-tested ideas and, most important, there is a shortage of ideas about how to get change started, how to get the ideas implemented.

These beliefs, in turn, lead me to the following conclusions: Fundamentally, there is a need for reinstitutionalizing the health-care industry to place the physicians and the hospitals in a posture vis-a-vis the consumer that is more typical of sellers and buyers in other markets.

As prices continue to rise, stronger pressures will build up toward change. While this paper has concentrated on possible actions by labor and/or management, it is obvious that the sparkplug role may be taken anywhere in the system—by the vendors, by the third parties, by the Government. But, in the light of current trends and present orientations, it may well be the major group purchasers who emerge as the major stimulant toward change.

POSSIBLE APPROACHES TO A COMPETITIVE ENVIRONMENT

What form will this change take? It is hard to say, of course. The situation is complex, and there are many social and political considerations. In this paper we have already mentioned several possibilities. The following discussion concerns these and additional possibilities:

Broad-scale development of prepayment medical centers.—Imagine the effect on the organization of health care and on costs if, in each urban area, there were prepayment community health centers, similar to those of the Kaiser plan, available as alternatives to the public. Other hospitals, independent physicians, and drug suppliers would be faced with adequate, but not overwhelming, competition.

Massive self-insurance indemnity programs.—The expansion by major group purchasers of their self-insurance indemnity programs is not a likely occurrence; among the major unions, at least, there is a strong preference for nonindemnity-type coverages.

Management-labor coalitions.—Regional coalitions of management and/or labor could bargain and negotiate directly with the vendors of health care, stimulate effectiveness in community-health-planning groups, institute improved claim-control systems, and in general assume the role of the consumers' representative. There is reason to believe that this type of coalition may be more than a dream. Recently, the California Health Plans Alternatives Committee was established by the Teamsters, Steelworkers, Carpenters, and Longshoremen in the State for this very purpose. It plans to invite members of industry shortly. There are several interesting elements to be observed. First, despite the fact that each of these unions already has advanced health plans, they still feel the need for a more forceful combination. Second, despite differences in philosophy, values, and pay rates, and despite continuing jurisdictional disputes, the unions can cooperate with each other on common problems. Third, despite geographical differences in their organizations and differing relationships with their national unions, these unions can overcome problems of regional autonomy when necessary.

Much of industry is no less concerned about the problem than is labor. It would seem, therefore, that, if a catalytic agent could be found that would bring together the major labor and management groups, it might be possible to form regional combinations that would be large enough to be effective.

A variation of this would be a regional coalition of management, labor, and Government to accomplish these purposes. In some areas, Government may be needed as the sparkplug to get things going. This may be the eventual shape of the comprehensive regional planning

activities created under Public Law 89-749, the Comprehensive Health Planning and Public Health Amendments of 1966.

Private-company operation of medical facilities.—A new private company, patterned after the American Telephone and Telegraph Company in State-by-State organization and after the Communications Satellite Corporation in ownership arrangements, could operate the Nation's voluntary, nonreligious hospitals and extended-care facilities on a for-profit basis. Owned by public shareholders, with prices and quality regulated by State agencies, such a company would provide the overall planning, direction, and control that are now lacking among hospitals.

With the additional stimulation of the profit motive, and of a size to permit economies of scale and command top-grade management, such a company should be expected to :

- (1) Remove duplication and fill in gaps of service;
- (2) Eliminate or convert noneconomic hospital plants;
- (3) Purchase centrally;
- (4) Create specialized centers for health care as needed;
- (5) Engage in continuous research and development, leading to improved technologies and new economies of management;
- (6) Find ways to reduce hospital construction costs;
- (7) Find better ways to serve professional staffs—physicians, researchers, dentists; and
- (8) In general, operate on a rational, coherent, cost-effective basis.

This company would not be granted a monopoly. Anyone could establish a for-profit hospital. Thus, a competitive element and an additional stimulus to efficient management would exist.

Establishment of such a company would be fraught with difficulties and unanswered questions. How would hospitals be induced to join? How would physicians be treated? How would proprietary hospitals fit into the system? Can urgent human health needs be handled in a way that is compatible with profit maximization? Can costs really be restrained if there is a guaranteed maximum-profit rate? These are a few of the serious questions that need discussion and exploration. The difficulties may be more apparent than real, and the potential advantages of this system may be sufficient to justify such further exploration.

Third parties as agents of major group purchasers.—Less drastic, and simpler in some ways to accomplish, would be a new relationship between major purchasers and third parties. It is doubtful that major purchasers are anxious to undertake radical new roles and responsibilities. Third parties, too, would certainly not be enthusiastic about their doing so. This suggests that there is substantial room for a revision of roles wherein the third parties—principally the Blues and the private carriers—would explore new approaches together with

management-labor groups. This, in itself, is not new; what is suggested is that it be done with a new "psychological set." The third parties would regard themselves as the agents of the major group purchasers rather than merely as financial conduits. They would, as agents, develop new bargaining relationships with the vendors of care; negotiate contracts with them; encourage competitive buying behavior by consumers; if warranted, move into service benefits; insist on more effective regional hospital planning; and actually be the countervailing force.

THE NEED FOR EVALUATION

In reflecting upon the health-care-cost problem, I have been struck by the lack of conclusive data that can be used for decisionmaking. In this regard, many people have pointed to the need to experiment with the many ideas that have been promulgated. Actually, experiments of a noncontrolled sort are already in process all over our country. This paper has only briefly touched on a few of these; there are many more. We should think of these as experiments and we should organize efforts to document what each is doing, to ascertain results, and to evaluate the experiences. It is too bad that such noble ideas as Health Insurance Plan of Greater New York, the San Joaquin Foundation for Medical Care, the program for hospital planning in Allegheny County, Kennicott Coppers' health program in Utah, the food industry's program in Los Angeles, and on and on, are not systematically studied by economists and management specialists so that the needed lessons could be learned.

With the Medicare program coming up for review by Congress within the next 12 months, it would seem in order to undertake an impartial, scholarly study, adequately staffed and funded, to evaluate its effects on health costs and develop recommendations for ameliorating the negative ones. It seems clear that the effects so far have been massive. To the extent that people who would otherwise not have received care did expand the demand, this is good. But any negative effects also need to be identified and evaluated with a view toward their elimination or reduction.

CONCLUSION

I believe that those who argue for allowing the consumer a substantial number of health-care choices are correct. Tastes and values differ and these differences should be respected.

There are no villains responsible for the soaring costs. What we have are responses to the forces of supply and demand, operating in a unique economic marketplace. What we therefore should seek to do is

reduce the differences in this market through improvements in its organization and productivity.

The soundest social programs are those that evolve because they are right for the time and place rather than those that are superimposed extraneously.

Ordinarily, the best way to create a competitive-market environment where one does not exist is by eliminating the barriers to competition. In the case at hand, however, I have been unable to find or think of any practicable way to put hospitals into a competitive framework or to set physicians to competing with their associates.

Through regional health planning, it is possible to effect some significant economies among hospitals. But it is doubtful to me that such an approach is a substitute for the sort of buyer-seller price- and quality-negotiating that is the essence of a competitive system.

Accordingly, I suggest in this paper that new, countervailing power arrangements be considered and, if deemed worthy, stimulated and nurtured. Through these, the effective, competitive conditions can be developed that are necessary, in my opinion, if health-care prices are to become market-responsive.

Several ideas of what these countervailing power arrangements might be have been presented. The one that seems the best for all, in my opinion, is that in which third parties adopt a new role—that of agent for the major group purchasers. In this role, the third parties would maintain their functions of risk control and health-care-money transfer, but in addition would act as negotiators and bargainers with the providers of health care. This would entail major changes in their product, their methods of procedure, and their perception of themselves.

As we look to the future, it seems inevitable that some, if not all, of the participants in the health-care model will have to change their viewpoints and behavior. Current positions are incompatible with our societal and economic values, and now the winds of change are blowing. Some will be actors, and some, reactors. It is difficult to say which group will be which; but certainly the third parties' group would seem from many viewpoints the best candidate for leadership if it can organize. If it doesn't, the task will devolve upon management and labor, or upon the Government.

2

State Laws and Health Insurance

STATE INSURANCE DEPARTMENTS, with their responsibility for regulating both insurance companies and, in most States, Blue Cross and Blue Shield plans, can exert a considerable degree of control over the type of health insurance available to the public and the terms on which it is provided.

This paper will endeavor to explore the various aspects of health insurance that are influenced by State insurance laws and State insurance department regulations, or that might be so influenced; it will raise certain questions regarding the present situation and suggest some changes in State laws that might be in the public interest. The discussion will emphasize health insurance policies providing hospital, surgical, and medical coverage; loss-of-time benefits will be considered only incidentally.

WHY INSURANCE IS REGULATED BY THE STATES

Although the insurance business is countrywide and many insurance companies operate in all 50 States and the District of Columbia, it is regulated by the States, not by the Federal Government. In contrast to the many aspects of American economic life supervised by Washington, insurance is the largest and most important segment of the economy left entirely (or almost entirely) to State control. How long this situation will continue, however, is in my opinion problematic.

The reasons for State regulation of what is generally conceded to be an interstate business are largely historical. Insurance regulation

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began as a State endeavor; in 1814 the New York Legislature passed "An Act to Prevent Foreigners from Becoming Insurers in Certain Cases in this State." In 1851 New Hampshire formed the first insurance regulatory body, followed quickly by Massachusetts and Vermont and, in 1860, New York. In 1868 the U.S. Supreme Court ruled that "issuing a policy of insurance is not a transaction of commerce."¹ The Court then argued that a State law regulating something that is not commerce is "not in conflict with the constitutional power of Congress to regulate commerce" and permitted the State of Virginia and, by inference, other States, to regulate insurance.

This surprising decision was not a temporary aberration; it was reaffirmed in many other U.S. Supreme Court decisions. It was not until 1944, in a case that involved a blatant violation of the Sherman and Clayton antitrust acts, that the U.S. Supreme Court ruled that the commerce clause grants to Congress the power to regulate insurance transactions stretching across State lines.² Even one of the dissenting justices (Robert H. Jackson) stated: "Were we considering the question for the first time and writing upon a clean slate, I would have no misgivings about holding that insurance business is commerce and where conducted across state lines is interstate commerce and therefore that congressional power to regulate prevails over that of the states. I have little doubt that if the present trend continues, federal regulations eventually will supersede that of the states."

Following the SEUA decision,³ State regulation and taxation of insurance were given specific congressional sanction in the Insurance Regulation Act.⁴ Congress declared "that the continued regulation and taxation by the several States of the business of Insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." It also said that "the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."

Until Congress revokes this mandate, health insurance, like other branches of this important interstate business, must take careful cognizance of the laws and regulations of the 50 States and the District of Columbia, as well as those Federal statutes and programs which affect private health insurance.

¹ In the case of *Paul v. Virginia* (8 Wall 168).

² *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944).

³ *Ibid.*

⁴ Public Law 79-15, 59 Stat. 33, March 9, 1945.

HEALTH INSURANCE CARRIERS

The laws of most of the 50 States recognize only two types of insurance companies: life insurance companies and property insurance companies. Life insurance companies may not write automobile or fire insurance, and property insurers may not write life insurance or annuities—but both may write health insurance. An insurer which desires to write only health insurance may, of course, do so; but it must incorporate as either a life insurance company or a property insurance company and meet the statutory requirements applicable to the class of insurers to which it has elected to belong. In 1965, 676 life companies and 290 property insurers wrote health insurance, as did 41 monoline health insurance companies (which must be, in corporate form, either life or property insurers.)⁵ Of these 1,007 insurers, 576 offered both group and individual insurance, 91 offered group insurance only, while 340 sold only individual health insurance policies.

Each of these insurers had to become incorporated in its State of domicile and raise an initial capital and paid-in surplus, ranging from \$25,000 in Arizona to \$150,000 in New York⁶ and \$1,500,000 in Michigan.⁷ It then had to obtain admission to each State in which it desired to do business, often a long and arduous road for an insurer wishing to operate countrywide. Its financial statements, reserves, and investments are subject to control by the State of domicile (though any State that is not satisfied as to an insurer's financial condition can withdraw its license to do business in that State), but policy forms must be submitted to each State in which they are to be issued, and the policy language must conform to the law of the State of issue. Underwriting statutes, such as those defining what constitutes a group, must also be complied with on a State-by-State basis.

Besides regulating health insurance companies, State insurance departments in 41 States are responsible for supervising Blue Cross plans (in two other States Blue Cross is regulated by a State agency other than the insurance department). This is, however, logical since, except in the case of New Hampshire-Vermont Hospitalization Service, Blue Cross and Blue Shield plans do not operate across State lines.⁸

MAIL-ORDER INSURERS

One major challenge to the pattern of regulation by each State of all insurance activities taking place within its borders has been the

⁵ 1966 *Source Book of Health Insurance Data* (New York: Health Insurance Institute, n.d.), p. 51.

⁶ Sec. 192.

⁷ Sec. 410.

⁸ Robert D. Eilers, *Regulation of Blue Cross and Blue Shield Plans* (Homewood, Ill.: Richard D. Irwin, 1963), p. 103.

activity of mail-order insurers. Their operations have taken place largely in the individual health insurance field. Attempts to sell life insurance by mail have, generally, been dismal failures. Automobile and fire insurance have seldom been sold by mail either. Health insurance, by contrast, has proved a fertile field for mail-order sales techniques, and many health insurance policies have been sold by mail, some by well-financed, responsible insurers using direct mail as an adjunct to their agency sales organization, and some by less responsible insurers. Indeed, it is in the field of mail-order health insurance sales that the epithet "fly-by-night" is most commonly heard.

Until 1950, mail-order insurers were completely free to incorporate in one State and operate, regulation-free, in all the others. If the State of incorporation was one with sufficiently lax insurance statutes, a mail-order insurer could escape effective regulation of any kind and could, in addition, escape taxation by all States other than its State of domicile. In 1950, one State, Virginia, attempted to regulate mail-order health insurance sales by means of its blue-sky law. The Virginia State Corporation Commission ordered Travelers Health Association, a Nebraska mail-order health insurer, to cease and desist from further solicitation or sale of policies to Virginia residents, unless and until it obtained authority in accordance with the Virginia blue-sky law. The U.S. Supreme Court upheld Virginia's use of the blue-sky law to obtain jurisdiction over an unauthorized mail-order health insurer, stating: "If Virginia is without power to require this Association to accept service of process on the Secretary of the Commonwealth, the only forum for injured certificate holders might be Nebraska. Health benefit claims are seldom so large that Virginia policyholders would afford the expense and trouble of a Nebraska law suit."⁹

The National Association of Insurance Commissioners also attempted to deal with the problem of unauthorized mail-order health insurers and bring them under the jurisdiction of the courts of the State where the policy was sold. The Unauthorized Insurers Service of Process Act, adopted by almost every State, defines "the making or proposing to make an insurance contract" or "the taking or receiving of any application for insurance," whether by mail or otherwise, as doing insurance business in the State. The statute provides that any insurer engaged in this type of business automatically designates the insurance commissioner of the State as his agent for service of process and that service of process of the commissioner gives the State courts jurisdiction over the mail-order insurer.

State insurance departments have not stopped at the Unauthorized Insurers Service of Process Act in their attempt to regulate or elimi-

⁹ *Travelers Health Assn. v. Virginia*, 339 U.S. 643.

nate the mail-order insurer. Many State insurance departments have asked local newspapers and radio stations to refuse to accept advertisements from unauthorized insurers and have periodically issued press releases urging the public to check with the insurance department before buying insurance by mail.

In recent years, some States have gone even further. Wisconsin levied a special premium tax on unauthorized insurers, taxing them at a higher rate than admitted insurers. Recently, also, the Wisconsin Supreme Court ruled that the discriminatory premium tax and the other restrictions placed on mail-order insurers doing business in Wisconsin were constitutional,¹⁰ and the U.S. Supreme Court refused to review the case.

California, too, has recently taken action against unauthorized mail-order insurers; the California insurance commissioner sued three such companies to prevent their doing business in that State without obtaining a certificate of authority. The California District Court of Appeals, relying on the *Ministers Life* case,¹¹ agreed with the commissioner and ruled that mail-order insurance is subject to regulation in California.

HEALTH INSURANCE ADVERTISING

Until 1954, State insurance departments were not concerned with the advertising done by health insurance companies. In that year, however, action was forced upon them by the Federal Trade Commission. The FTC cited a large number of insurance companies, among them some quite prominent ones, for false and misleading advertising of health insurance policies. The position of the FTC was that the Insurance Regulation Act¹² provided only a limited exemption for insurance from Federal statutes and that the Federal Trade Commission Act is applicable to insurance "to the extent that such business is not regulated by state law." Since State insurance regulations were silent on the subject of advertising, the FTC believed it had the power to act in this field.

After the citations, but before any of the cases were finally decided, an all-industry committee, consisting of representatives of the insurance companies and of State insurance departments, drafted a set of rules governing insurance advertising; by 1959, two-thirds of the States had adopted these rules. By the time the first case reached the U.S. Supreme Court, in 1957,¹³ most States had adopted the necessary regulations, and the Supreme Court held that the Insurance Regulation Act "withdrew from the Federal Trade Commission the authority

¹⁰ *Ministers Life and Casualty Union v. Haase* (30 Wis. 2d 339, 1966).

¹¹ *Ibid.*

¹² Public Law 79-15.

¹³ *Federal Trade Commission v. National Casualty Co.* (357 U.S. 560).

to regulate respondents' advertising practices in those State which are regulating those practices under their own laws."

The Federal Trade Commission did not give up, however, and successfully asserted its right to regulate the advertising of mail-order insurers when the U.S. Supreme Court ruled that the existence of State laws regulating advertising did not oust the Federal Trade Commission from jurisdiction over mail-order insurance, since the State in which policies are sold has no effective way of regulating the advertising of mail-order insurers.¹⁴ Subsequent to this decision, the FTC issued, in July 1964, its Guides for the Mail Order Insurance Industry; most of these mail-order companies, as mentioned above, sell health insurance.

The legal authority of the States to regulate insurer advertising is found in the Uniform Trades Practices Act.¹⁵ These statutes, which were enacted by every State soon after the adoption by Congress of the Insurance Regulation Act, are intended to "regulate trade practices in the business of insurance" and define and prohibit practices "which constitute unfair methods of competition or unfair or deceptive acts or practices." Among other unfair trade practices, the following are prohibited: "misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby" and "publishing . . . an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance . . . which is untrue, deceptive, or misleading." This same Uniform Trades Practices Act contains an antidiscrimination section pertaining to health insurance that prohibits "permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium . . . or rates charged."

POLICY FORMS

For some types of insurance, such as fire insurance and automobile insurance, State law or industry practice has resulted in a standard policy form, used by all insurance companies wishing to offer this type of coverage. In health insurance, by contrast, standard policy forms have never been required by law, nor has industry practice yet achieved this result, though there is some evidence that individual health insurance policies are less heterogeneous than they use to be.

Although health insurance policy forms must, in all States, be filed with and approved by the insurance commissioner before being used,¹⁶

¹⁴ *Federal Trade Commission v. Travelers Health Assn.* (362 U.S. 293, 1960).

¹⁵ E.g., Michigan Insurance Code, secs. 2001 to 2050.

¹⁶ *Ibid.*, sec. 2236.

insurance departments are mainly concerned with the form, not the substance, of the policy. Besides requiring certain uniform policy provisions, which will be discussed below, the insurance code permits the commissioner to disapprove a policy "if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of such policy."¹⁷

The uniform policy provisions required in every individual health insurance policy date from 1950. Prior to that date, similar provisions, called "standard provisions," were required by most States. The standard provisions, however, had to be included verbatim, in the same words and the same order as in the statute, and this placed insurers in a strait jacket and prevented not only experimentation but also provisions more favorable to the policyholder than those required by law.¹⁸

This situation was changed with the adoption of the uniform policy provisions, which, after approval by the National Association of Insurance Commissioners in 1950, have been adopted by every State. These 12 required provisions and 11 optional provisions must be included "in substance," not verbatim. The law states that "the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary."¹⁹ This intelligent approach to insurance regulation guarantees to the policyholder the protection he needs, while permitting the insurer to experiment with language that may be better for the insured than the statutory wording.

UNIFORM PROVISIONS

The 12 uniform provisions required to be included in every individual health insurance policy deal with such matters as the method of giving notice of claim and proof of loss, cancellation and reinstatement, the grace period and change of beneficiary, and the time and method of paying claims. The 11 optional provisions pertain to prorating benefits in event of a change of occupation, misstatement of age, or the existence of other insurance covering the same loss, and also include an optional 5-day cancellation provision. Two of the optional provisions do touch on the policy exclusions, since they permit the insurer to exclude losses contributed to by the insured's being engaged in an illegal occupation, committing a felony, or being intoxicated or under the influence of narcotics.²⁰

¹⁷ *Ibid.*, sec. 2242.

¹⁸ Edwin J. Faulkner, *Health Insurance* (New York: McGraw-Hill, 1960), p. 486.

¹⁹ Michigan Insurance Code, sec. 3406.

²⁰ *Ibid.*, secs. 3406 to 3454.

Except for these two optional provisions, the uniform policy provisions required by law do not affect coverage, exclusions, or benefit levels. An insurer is still free to combine coverages in any way it likes, to include or not include inhospital surgical or medical care, ambulance, anaesthesia, or other services with hospital insurance; it may use any relationship it wishes between the hospital room-and-board benefit and the allowance for miscellaneous services or may make them independent if it chooses to do so; it may offer any level of hospital daily benefit, any maximum period of coverage, any surgical schedule or ancillary benefits it sees fit. As a result of the great number of possible combinations of benefit amount, length of stay, ancillary benefits, and surgical schedules—often combined with a great variety of income coverage for loss of time because of accident or sickness—health insurance has become the most heterogeneous and confusing type of insurance. It is almost impossible for the purchaser of an individual health insurance policy to compare benefits and costs, and shop intelligently for his health insurance policy. The existence of guaranteed renewable, conditionally renewable, and cancelable policies—with different levels of cost—does nothing to simplify the task of the health insurance buyer.

DUPLICATION OF COVERAGE

The experience of insurance companies has indicated that overinsurance against any peril can be a serious problem. Whether in life insurance, fire insurance, or health insurance, the existence of more insurance than is needed to cover the insured's economic loss creates an opportunity for profit rather than loss, if the insured event happens. This creates a moral hazard that, as insurers have learned through sad experience, must be avoided. Although the problem of overinsurance is less acute in health insurance policies covering medical and hospital care than in policies providing loss-of-time income benefits, it exists, nevertheless, and must be dealt with.

Our society is characterized by a high proportion of working wives—many of them working in companies that provide health insurance—and by a widespread inclusion of dependent coverage in health insurance policies. This combination of circumstances has given rise to such quaint devices as “switch maternity” benefits, which transfer maternity benefits from the husband of a working wife, the husband being entitled to them under dependent coverage but presumably not needing them, to the working wife herself. It has also contributed to a steadily worsening duplication problem—caused by both husband and wife having group health insurance or Blue Cross, each providing dependent coverage—resulting in double payment for many hospital

and medical expenses. The duplication can result from one Blue Cross and one group insurance contract or two group insurance contracts. This duplication is in addition to that resulting from group or Blue Cross plus individual hospital or medical insurance. Duplication cannot usually arise between two Blue Cross contracts, unless husband and wife work in different States. There may indeed be duplicate coverage, but the Blue Cross payment mechanism insures that the hospital will only be paid once and that the subscriber, who is not paid directly, cannot profit.

State law, in the form of the uniform provisions, seems to recognize only the possibility of duplication between individual health insurance contracts, and then primarily in the loss-of-time area. Four of the optional uniform provisions that may be included in individual health insurance policies are concerned with overinsurance. One deals with overinsurance due to the issuing of two similar policies by the same insurer; one, with loss-of-time coverage in excess of the insured's monthly earnings; and two, with duplicate coverage with other insurers.

As the proportion of people covered by hospital and medical insurance has grown, insurers and Blue Cross plans have become more cognizant of this problem and have begun to take steps to solve it. Antiduplication clauses have begun to appear in some group insurance policies, notably in major medical policies, but so far no solution has been found to the problem of duplication between Blue Cross and group health insurance or between either group insurance or Blue Cross and individual policies.

That this problem is an important and growing one is indicated by the estimate of the Health Insurance Council that in 1965 there were 67,104,000 people covered by group hospital-expense insurance, 41,420,000 covered by individual and family hospital insurance, 64,495,000 covered by Blue Cross, and 7,376,000 by independent plans (such as group-practice prepayment plans.) This total of 180,395,000 represents, says the Council, 156,047,000 people, which means that about 15 percent of the persons with hospital-expense coverage are eligible for benefits under more than one policy.

The National Association of Insurance Commissioners and a committee of the Health Insurance Association of America began a study of overinsurance in December 1959. The purpose was to amend the uniform provisions to make them more effective as a barrier to overinsurance. In December 1963, the NAIC received from the HIAA committee a draft of a proposed statute that would replace three of the four optional uniform provisions with two new ones, with the aim of making these provisions more effective in preventing overinsurance. One of these provisions affects only loss-of-time coverage,

but the other permits the inclusion, in hospital, surgical, medical, and major medical policies, of an antiduplication provision that would prorate the benefits provided by the policy if the insured had other valid coverage applicable to the same hospital or medical expense that, in total, would pay more than 110 percent of the expenses incurred.

The proposed statute drops the irrelevant clause included in the 1950 uniform provisions that makes the antiduplication clause applicable only to coverage of which the insurer has not received written notice from the insured before the loss occurs. It also permits the definition of "other valid coverage" subject to the prorating clause to include—in addition to individual policies—group, blanket, and franchise coverage, Blue Cross-Blue Shield plans, benefits under any union welfare plan, workmen's compensation insurance, or automobile medical-payments coverage.

The 1963 HIAA proposal is a substantial improvement over the 1950 uniform provisions and, for the first time, would permit a true antiduplication provision in hospital and medical-expense insurance. Unfortunately, the States have, to date, shown no great eagerness to adopt the new model statute.

In addition to the duplication between different types of hospital and medical-expense coverage, there is also duplication between health insurance policies and automobile liability insurance and medical-payments coverage. The single-limit Special Automobile Insurance Policy has an antiduplication provision in its medical-payments coverage; it contains a subrogation clause that applies to medical-expense insurance as well as to liability and physical-damage coverages. Furthermore, medical-payments insurance under the Special Automobile Policy is in excess of individual, blanket, group, accident, disability, or hospitalization insurance; any payment made by any type of private insurance towards an injured party's medical expenses will preclude payment of this amount by the Special Automobile Insurance Policy medical-payments coverage. The Family Automobile Insurance Policy, still the most common auto policy in the United States, permits double recovery; the insured or an injured passenger in the automobile can collect both from his automobile insurance and from Blue Cross or a private insurer. In fact, an injured passenger who has a valid liability claim against the driver (one that survives the guest statutes in effect in many States) may collect his hospital bill three times: from his own or his host's medical-payments insurance, from a negligence-suit recovery, and from Blue Cross, group hospital insurance, or an individual policy.

It is clear that duplicate coverage feeds the fires of hospital- and medical-cost inflation and results in higher insurance premiums for all policyholders. There seems to be no real justification for

the enrichment of someone unfortunate enough to have had an accident, and the duplication may present a real underwriting hazard, which State law should curb.

In Nathan Sinai's words, "the dictum of no profit to the insured is a purifying principle. Let it be violated, by design and to any appreciable degree, and the whole stream of insurance becomes polluted."²¹

SUBROGATION

Most automobile, fire, and other types of property insurance policies contain a subrogation clause. If an insurer must pay for the repair of an insured's automobile under his collision insurance, it is subrogated to the insured's rights to sue a third party whose negligence may have caused the damage. Subrogation also applies to liability insurance, but the Family Automobile Insurance Policy does not contain a subrogation clause applicable to medical-payments coverage. If the injured party in an automobile accident is a passenger in the car, and if the State in which the accident happened does not have a "guest statute" prohibiting negligence suits by passengers (except for gross negligence), the injured passenger may be able to collect his medical bills from his host's insurer under the medical-payments coverage, then sue him for an amount that includes the medical bills. Some courts will deny double recovery in such a case, but others will not. If the medical bills of an automobile-accident victim have been paid by Blue Cross or private health insurance, the injured person can generally include them in the amount for which he sues and collect twice.

What is often not realized is that, in the case of property or liability insurance, subrogation, in addition to being included in the policy, is a common-law right. This does not, apparently, hold for medical-payments coverage; in order to obtain the right of subrogation, it was necessary for automobile insurers to include a subrogation clause in the Special Automobile Insurance Policy, a single-limit type of policy that is gaining in popularity among motorists. A passenger whose host has this type of insurance cannot collect twice from the same insurer. By paying his medical bills under the medical-payments coverage, the insurer is subrogated to the injured party's right to collect from the driver who caused the accident. Thus, if the injured passenger collects a second time, from the negligent driver, he must repay the insurer that actually paid his medical bills.

It would be helpful if private health insurance, too, had subrogation rights and if Blue Cross or group hospital insurance, having paid a policyholder's hospital bill, could assume his right to sue if the

²¹ Nathan Sinai et al., *Disability Insurance in California* (Ann Arbor: School of Public Health, University of Michigan, 1965), p. 122.

accident causing the hospitalization were due to someone's negligence, and be reimbursed for its outlay. Michigan Blue Cross thought that it did have this right, by common law, but the Michigan Supreme Court ruled that common law and equitable principles of subrogation did not permit Blue Cross to exercise subrogation rights, even if its policyholder collected in a liability suit, for the hospital bills Blue Cross had paid!²² In a companion case, however, Michigan Blue Shield was permitted to recoup the amount it had paid for Sharpe's medical expenses, because Blue Shield, in contrast to Blue Cross, had a subrogation clause in its contract.

It seems logical for all Blue Cross and Blue Shield contracts, as well as group and individual hospital, medical, and major medical policies, to contain subrogation clauses. The duplication of benefits resulting from the ability of some injured person to collect his medical and hospital bills more than once, by suing a negligent driver for amounts not actually expended by the plaintiff, makes little sense from a social point of view and can only add to the already rapidly increasing cost of health insurance and Blue Cross-Blue Shield coverage. Perhaps State law should require such a subrogation clause in all health insurance policies.

CANCELLATION

As mentioned above, one of the optional uniform provisions that may or may not be included in an individual health insurance policy, at the option of the insurer, is a clause permitting the insurer to cancel the policy on 5 days' notice. Cancellation, of course, does not affect a claim that has already occurred, but effectively prevents an insurer from having to pay future claims for an individual whose past claim history implies that he may be a substandard risk. This type of cancellation clause, similar to that found in an automobile or fire insurance policy, seems to make little sense in health insurance; it permits an insurer to terminate coverage just when the policyholder needs it most. Recognizing this, some States have enacted legislation prohibiting cancellation of health insurance contracts between policy anniversaries.

Fortunately, most insurers do not utilize a cancellation provision in individual health insurance policies, even where permitted to do so. However, most health insurance policies are, in form, 1-year contracts, and the absence of a cancellation clause merely guarantees protection for 1 year. Unless this right is specifically stated in the policy, nothing requires the insurer to renew an individual health insurance policy. In the absence of a statute or a policy provision that

²² *Michigan Hospital Service v. Sharpe* (339 Mich. 357, 63 N.W. 2d 638, 1954).

limits its freedom in this regard, an insurer may refuse to renew, on its anniversary, the hospital or medical insurance policy of someone whose health has deteriorated since the policy was purchased or who may have chronic ailments that might require further hospitalization or medical care. Or, if it wishes, the insurer may offer to renew the policy, but only after attaching a rider excluding coverage for the condition which seems most likely to require further medical attention.

The statute that goes furthest in limiting the right of insurers to refuse renewal is New York's section 164. This statute prohibits an insurer from refusing to renew, after two years from its date of issue, any hospital or medical-expense insurance policy "because of a change in the physical or mental condition or the health of any person covered thereunder." Restrictive riders limiting the benefits are also prohibited.

Categorized in the order of increasing security as to renewability, there are currently five different types of hospital and medical-expense contracts sold in the United States:

Cancelable policies.—Cancelable policies give the insured or the insurer the right to cancel at any time, on 5 days' written notice. This type, formerly prevalent, has diminished to a trickle, though the trend has been caused primarily by competition, not by statute.

Policies renewable at the option of the company.—Policies that are renewable at the option of the company cannot be canceled between anniversary dates, but the insurer has the right to renew or not, at its option, on any anniversary. Of course the insured also reserves the right to terminate the policy; all he has to do is neglect to pay the premium for the next year's insurance. These policies, together with those that are actually cancelable, make up the bulk of the so-called commercial policies, characterized by relatively modest, short-term benefits. Little by little, this type of policy is losing ground to contracts providing broader and longer-term benefits and including restrictions on the insurer's right to refuse renewal.

Conditionally renewable policies.—Conditionally renewable policies restrict the company's right to cancel or refuse to renew an individual policy, but permit it to refuse renewal of an entire class of policies. This type of clause, sometimes called "renewal guarantee," usually defines what is meant by refusal to renew a class of policies. Some contracts, for example, reserve to the insurer the right to refuse to renew all policies issued on the same policy form to persons residing in the same State. Others simply enumerate certain reasons, such as the bad health of an individual, that the insurer cannot use as grounds for refusal to renew. A conditionally renewable policy does protect the unfortunate policyholder whose health deteriorates, making him more likely to need hospital and medical treatment. If scrupulously used

by the insurer, a "renewal guarantee" clause may provide almost the same degree of protection to the insured as a guaranteed-renewable policy, while protecting the insurer against a disastrous claims experience owing, perhaps, to Federal or State legislation that makes it unprofitable to continue writing health insurance of a certain type in a certain region. Of course, a "renewal guarantee" clause guarantees only the right to renew the policy; the insurer reserves the right to change the premium rate, but only for the entire class of policyholders. An individual policyholder is protected against an upward revision of his rates because of a change in his health.

Guaranteed renewable policies.—Policies that are guaranteed renewable, usually written by life insurance companies and providing long-term, broader benefits, completely eliminate the right of the insurer to cancel or refuse renewal of the policy. Of course, most such policies terminate at a specific age, often age 65, especially since the advent of Medicare. The insurer must and does reserve the right to increase premiums when necessary, since no one can predict the future course of hospital and medical costs. However, any premium increase must be applied without discrimination to all policies in a class, not just to individuals in poorer-than-average health.

Noncancelable policies.—The term "noncancelable" is reserved, by industry usage and NAIC rule, to policies that guarantee not only the right to renew, but also the right to renew at a specific premium. For obvious reasons, few if any such policies include hospital or medical-care coverage.

The trend towards guaranteed-renewable hospital and medical-expense insurance and the propensity, even of insurers offering short-term benefits under "commercial" health insurance policies, to restrict their right to refuse renewal are illustrations of the advances in contractual provisions that can result from competition and broader awareness on the part of the buying public of the differences between types of health insurance policies. State law and the action of the National Association of Insurance Commissioners, while encouraging insurers to offer broader renewal rights, have generally followed, rather than led, industry practice. Only 10 States do not permit an insurer to write policies cancelable on 5 (sometimes 10 or 30) days' notice. Some States require that any right of the insurer to cancel or refuse renewal be prominently stated on the face of the policy. But the very real shift in individual health insurance from "renewable at the option of the company" to "guaranteed renewable" is due primarily to the decision of individual companies, governed by market and competitive considerations, to offer the latter rather than the former type of policy.

BENEFIT LEVELS AND PREMIUM RATES

Unlike automobile insurance or fire insurance rates, premium rates for health insurance are not regulated by State insurance departments. From time to time there is a demand in some quarters for such regulation, but in the highly competitive environment in which health insurance exists it would be difficult to justify rate regulation. The basic reason for rate regulation in property and casualty insurance, after all, is that companies offering these coverages sought and received exemption from the Sherman and Clayton antitrust laws, and in view of the practice of ratemaking in concert, regulation of rates by State insurance departments was needed to prevent monopolistic and anti-social practices.

As in all other types of insurance, except ocean marine insurance, health insurance policy forms must be filed with the insurance commissioner, who may disapprove the policy form and thereby prevent its use. In addition to the usual legal grounds for disapproval, the commissioner in 17 States may disapprove "(a) if the benefits provided are unreasonable in relation to the premium charged, or (b) if [the policy form] contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation." The former provision, in particular, is unique to the health insurance field.

This language, governing the relationship of benefits to premiums, may in some States be considered an invitation to rate regulation. An insurer must submit, to any State insurance department requesting the information, the loss ratio on each health insurance policy form. This information provides data that can be used by the States to determine whether benefits are reasonable in relation to premiums; i.e., whether premium rates are so high as to result in very low loss ratios. The National Association of Insurance Commissioners, in an attempt to establish guidelines for enforcing this rather ambiguous provision, adopted in 1953, a benchmark of a 50-percent loss ratio. By implication, any policy form that has a loss ratio of less than 50 percent over a substantial period of time offers "benefits unreasonable in relation to the premium charged." However, the problem of enforcing this standard is not an easy one; few insurers issue enough policies on a particular form to produce credible experience in one or even 2 years. It is generally necessary to use an experience period of several years to be able to say that the policy form really has a loss ratio of less than 50 percent.

Furthermore, this standard is of limited usefulness where a new policy form is concerned. In fact, the insurance business has contested the right of the insurance commissioner prospectively to disapprove

a policy because he believes that the loss ratio will be less than 50 percent. It is argued that this constitutes rate regulation and that the statutory language does not go so far. Buttressed by a legal opinion of counsel, and by the dicta in *Old Republic Life Insurance Co. v. Wikler*,²³ New York treats the "benefits unreasonable in relation to premiums charged" language as a rate-regulatory statute and insists upon prior approval of better insurance rates.

Five States do require the filing of estimated loss experience by policy form and, presumably, refuse to approve policies for which the estimated loss ratio is less than 50 percent. However, it takes several years before the insurance department can really test the relation of actual to estimated loss ratio, and, at that time, even if the actual loss ratio is well below the estimated ratio, there is nothing to stop the insurer from filing a new policy form, different from the previous one in some respects but generally similar, and stating that its estimate is that the loss ratio on this new form will be higher than 50 percent.

Only New York has really used the statutory language to endeavor to determine whether a newly filed policy form will in fact have a loss ratio exceeding 50 percent. This determination requires a careful pricing of all the benefits included in an individual health insurance policy form, taking account of the class of persons for whom the form is intended and of the underwriting and claims-handling procedures of the insurer involved.

If State insurance departments believe it is their duty to insure the provision of greater benefits to health insurance policyholders, the right to disapprove policies whose benefits are unreasonable in relation to premiums charged can, by a suitable interpretation of what is unreasonable, be made to provide considerably more authority than is currently being used.

BENEFIT LEVELS IN INDIVIDUAL HEALTH INSURANCE POLICIES

State law has been almost completely silent on the question of whether the benefits offered by individual health insurance policies are adequate to meet the needs of the policyholder. In fact, a committee of the National Association of Insurance Commissioners studied the question of whether minimum-benefit legislation should be passed, but the committee was discharged in 1952 without having proposed any model legislation. Only California, with its 1949 Minimum Benefits Law, attempts to require that health insurance policies provide benefit levels that meet certain minimum standards. This law has proved difficult to enforce and interpret and has not been adopted by other States.

²³ 175 N.E. 2d 147.

The absence of such standards, coupled with widespread ignorance of the true cost of hospitalization and doctors' bills, has permitted some insurers to issue policies that can by no stretch of the imagination be considered as meeting the policyholder's coverage needs. Thus, hospital insurance policies providing \$10 per day for room and board in areas where hospital charges are closer to \$40 are not uncommon. Many individual hospital insurance policies do not provide a lump sum to cover hospital extras; instead, they often itemize the benefits payable for specific hospital expenses. Thus, one widely sold hospital insurance policy pays a maximum, for any one sickness, of \$35 for use of the operating room, \$35 for anethetics, \$25 for X-ray examinations and electrocardiograms, \$10 for laboratory tests, \$25 for medicines and drugs, \$25 for blood plasma, and \$25 for oxygen. This fragmentation of benefits, together with the relatively low amounts made available, insures that few policyholders will be able to collect an amount even approaching their full costs for a hospital stay. A 100-day hospital-room-and-board benefit that ranges from \$10 to \$40 per day, at the insured's option, and a surgical schedule that pays \$79 for an appendectomy, \$34 for a tonsillectomy, and \$225 for heart surgery complete the coverage. Medical-expense insurance policies covering doctors' bills after a deductible of two or three visits often pay only \$5 for a home call and \$3 for a visit to the doctor's office; these amounts can seldom be sufficient to cover even half the cost of a doctor's services.

The argument is often made that inadequate benefits in an individual health insurance policy are not really too important since the insured may, if he wishes, buy several policies; as stated above, an antiduplication or prorating clause is rarely, if ever, present. Would it not be better, however, to offer adequate benefits in each policy and to discourage, by an appropriate antiduplication clause, the purchase of more than one policy?

GROUP INSURANCE ELIGIBILITY REQUIREMENTS

Many State laws define group health insurance in such a way as to limit, to a varying degree, the classes of persons who can qualify for group insurance. In 1940, the National Association of Insurance Commissioners recommended that the States adopt a model group accident and health insurance bill. Revisions in the recommended model bill were presented to the NAIC in 1950, 1954, and again in 1957. By 1961, 34 States had adopted one form or another of the model group health insurance bill, defining group health insurance and, in 16 States, specifying the minimum number of persons composing a group.

The definition of a group may be quite elaborate; the New York Insurance Law, for example, defines six different kinds of groups, each

with different requirements as to minimum size and participation.²⁴ New York differentiates between group health insurance policies issued to an employer, to a trade association, to a labor union or other employee association, to a multiemployer or joint union-employer welfare fund, to a creditor group, and to a public welfare district. Each of the six classes, which are the only types of groups to which a group insurance policy may be issued, must meet certain, specified requirements. Running through the various requirements are a few common threads: A group must have been formed for a purpose other than obtaining insurance (and, to guarantee this, a trade association must have existed for at least 5 years). The minimum number of covered persons needed to constitute a group varies from two for an employer-employee group to 100 for the employees of members of a trade association; the number increases as the group becomes less homogeneous and more likely to include persons who joined the group just to get the insurance. The amount of coverage must usually be based upon a plan that precludes individual selection, and, if the employee contributes to the cost of the insurance, at least 75 percent of the employees must agree to purchase the insurance, while an employer who pays the entire cost must insure all his employees or all those belonging to the class (such as white-collar or clerical employees) covered by the policy.

It is clear that the group-health-insurance definition, at least in those States having the strictest laws of this type, is basically an underwriting statute, intended to prevent the issuance of group insurance to a group of persons who associate merely to obtain cheap insurance. Such a group might cause antiselection to the insurer, since it would normally comprise persons more anxious than the average to purchase coverage and hence, in some cases at any rate, be more likely to include a disproportionate number of substandard lives. It might also be argued that the practice of granting low-cost group health insurance without some definite underwriting rules that served to distinguish it from individual insurance would contravene the Robinson-Patman Antidiscrimination Act and leave insurers open to the charge of unfair discrimination between group and individual policyholders.

Some persons have felt that a relaxation of State laws defining a group, so that group health insurance could be made available to more persons than can presently benefit from this type of coverage, might result in broader and less expensive health insurance coverage for many Americans. This conclusion becomes self-evident to some when they contrast the 90-percent loss ratio, common in group hospital

²⁴ Sec. 221.

and medical insurance, with the 50 to 60 percent that is common in individual policies.

The case for an expansion of group health insurance and a consequent contraction of individual insurance is not, however, so clear-cut. First, it must be pointed out that 16 States have no statutory definitions of group health insurance; yet the types of groups written in those States do not differ greatly from those written in States with legal restrictions. Most of the underwriting rules embodied in statutes such as New York's are safeguards of a type that would be adopted by a prudent insurer even in the absence of legal coercion.

Second, the comparison of loss ratios on group insurance and individual insurance referred to above is not entirely valid. The loss ratio of 90 percent or more, commonly experienced by major insurance companies in group hospital and medical insurance, is greatly affected by the volume of large group accounts, which, because of their size and the large amount of the administrative and claims work done by the employer rather than the insurer, are inexpensive to administer and hence can be written at a premium only 5 to 10 percent greater than the claims incurred. This is by no means true for a group of five to 10 employees, the size group that would be a more accurately comparable to individual health insurance. The loss ratio for a very small group can seldom be permitted to exceed 65 percent, since the balance of the premium is needed for acquisition and administration expenses and taxes. Furthermore, a non-employer-employee group, especially one requiring the insurer to collect part of the premium from various sources, convince various small segments of the group to purchase the coverage, and then keep it in force, might be almost as expensive to administer as individual insurance.

It is possible that some advocates of broader group insurance coverage are really urging, not merely more economical coverage as contrasted with individual insurance policies, but an arrangement that requires the employer to share in the cost of employee and dependent health-insurance care. It should be recalled that, as Nelson Cruikshank has remarked, the labor unions used group health insurance plus the collective-bargaining mechanism in lieu of a comprehensive, federally legislated program for health care. Health-care financing is, to some extent, using the insurance mechanism for a purpose for which it was not designed.

COMPULSORY HOSPITAL INSURANCE

In 1943 Rhode Island passed the first compulsory State disability-benefits law, requiring employers to provide short-term loss-of-time coverage, paid for by employer and employee contributions, from a

State insurance fund. Subsequent legislation of a similar type was passed in California, New Jersey, and New York, though these three States permitted private insurers to provide the coverage in competition with a State fund.

Only California requires hospital-insurance coverage, and it is limited to \$12 per day for 20 days. The other State laws stipulate only loss-of-time coverage for a 26-week period, in most cases with a modest maximum benefit.

In February 1967, however, New York's Governor proposed that New York State add hospital and surgical coverage for all employees to its disability-benefits law. Coverage would apply to employers of three or more people and would include 31 days' hospital benefits, maternity benefits, and inhospital medical and surgical benefits. Employers and employees would share the cost equally, and benefits provided by existing private insurance plans would have to be brought up to the level specified by law.

Although the New York proposal did not pass in 1967, it is a straw in the wind and may well indicate another avenue by which State law may encourage insurance covering the cost of hospital and medical care.

REGULATION OF BLUE CROSS, BLUE SHIELD, AND SIMILAR PLANS

Blue Cross plans are regulated by State law in 44 States; in 41 of these, by the insurance department. Thirty-five States have special enabling legislation for Blue Shield plans, and the vast majority are regulated by the State insurance departments. In most of these States, Blue Cross and Blue Shield plans are not subject to the same laws as are insurance companies; in many respects, the insurance department has more authority over Blue Cross and Blue Shield plans than over insurance companies.

Furthermore, State law, and the insurance commissioner at his discretion where the law is not specific, can determine whether Blue Cross can offer outpatient and nursing-home care or, for that matter, nursing service in the subscriber's home. Blue Shield plans may be limited to those offering prepaid medical and surgical care, or dental-service corporations can also be permitted to operate. Conceivably, too, out-of-hospital drug coverage may be provided through a prepayment plan, either by a separate corporation specifically authorized by statute or by broadening the coverage that Blue Cross may offer its subscribers.

In Michigan, under the act that governs the Michigan Blue Cross Plan,²⁵ the insurance commissioner must be satisfied that "the rates to

²⁵ Public Law 109 (State of Michigan).

be charged and the benefits to be provided are fair and reasonable." Identical language is found in the State law applicable to Blue Shield plans.²⁶ In the case of Blue Cross, "all acquisition and administrative expenses in connection with such hospital service plan shall at all times be subject to the approval of the commissioner of insurance." Thus, the insurance commissioner has more authority over Blue Cross and Blue Shield rates, expenses, and benefits than he has with respect to insurance companies.

The insurance commissioner, under this broad legislative grant, may, for example, refuse to permit Blue Cross to issue indemnity contracts and may insist that only service benefits be offered. He may grant, or refuse, permission to experience-rate groups of subscribers, a crucial matter in competition with insurers for large employee groups. He may limit Blue Shield to inhospital medical and surgical coverage or may permit coverage of home and office visits as well, and he may insist, as a condition for rate approval, that Blue Shield participating physicians accept a specified fee schedule for Blue Shield subscribers with incomes of less than a predetermined amount. Or, if he believes it would be in the public interest, he may permit Blue Shield to pay the doctor's customary charge for subscribers of all income levels.

It is clear that State law, in Michigan and many other States, has given the insurance commissioner a very broad grant of authority over the scope of benefits and the level of charges made by Blue Cross and Blue Shield plans. A judicious use of this power can induce these organizations to "run a tight ship" and exercise, in their turn, careful supervision over the hospitals and doctors who receive a major portion of their income from them. When Blue Cross and Blue Shield cover 30 to 40 percent of the population of a State, as is the case in Michigan, their economic leverage over hospitals and, to a lesser extent, doctors cannot help but be a substantial influence, for good or ill, on the cost and quality of medical and hospital care.

In particular, the question of service versus indemnity benefits is extremely important, and State law can be quite influential in this area. The provision of service benefits by Blue Cross is highly desirable if one of the goals of prepaid health-insurance coverage is the provision of adequate benefits to the public. The 1965 Health Insurance Institute study shows that only 34 percent of the employees protected by basic group insurance plans, which are generally on an indemnity basis, had daily benefits of \$20 or more.²⁷ The study also in-

²⁶ Public Law 108 (State of Michigan).

²⁷ *Group Health Insurance Policies Issued in 1965* (New York: Health Insurance Institute, n.d.), p. 5.

dicated that, in five of the nine regions of the United States, the average daily room-and-board benefits provided by new group health insurance policies issued during 1965 were 80 percent or less of the average daily room-and-board charge for semiprivate accommodations in the area. If 80 percent is considered an adequate benefit, then approximately half the employees covered by new group plans have inadequate benefits. Presumably, a still larger proportion of those covered by older plans, negotiated when hospital costs were considerably lower, have inadequate benefits, to say nothing of the 20 to 30 million people whose only hospital-expense protection consists of individual policies.

CONCLUSION

In some ways the insurance business is now in a position regarding State law that is analogous to the automobile industry's position regarding Federal safety standards. The broader the coverage of a policy, the more it costs. Insurance companies have always argued that all types of contracts were available in the marketplace—that an insured could select as much "optional equipment" as he wanted to pay for. However, just as the Federal Government has legislated certain safety standards for automobiles and required seatbelts, collapsible steering wheels, and padded dashboards, even though they may raise the price of the car, it may be time for State insurance laws to consider taking the same route and stipulating minimum standards for hospital- and medical-insurance policies. These minimum standards would certainly have to encompass benefit levels, periods of coverage, cancellation and conversion clauses, and perhaps other features. From the insurer's point of view, the best defense against this type of legislation is to achieve its goals without compulsion. State laws have proved unnecessary in many areas of insurance; progress towards broader benefits and more liberal policy provisions has taken place without coercion, by voluntary industry action. I hope this will be true of health insurance.

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Walter J. McNerney

3

Improving the Effectiveness of Health Insurance and Prepayment

IF ONE WERE BRASH ENOUGH to attempt to describe the current system of providing and financing health services in the United States in one sweeping adjective, the most likely choice would be "pluralistic." To the uninitiated, such an attribution suggests little more than "variety" or "complexity"; it does little to reveal how the system operates or, in fact, what the system is.

And yet the adjective is appropriate. In the United States, health services are owned, operated, and financed under a multitude of auspices. Of the 6,292 short-term hospitals in the country, 3,478 are owned and operated by nonprofit corporations, 896 are owned and operated by proprietors on a profit basis, and 1,918 are owned and operated by government.¹ Within the nonprofit category there are church, community, and association groupings. Within government there are Federal, State, and local operations. The Federal Government operates veterans' hospitals, hospitals for merchant seamen, and other special hospitals, as remote from one another systemwise as from nonprofit corporations. Turning to nursing homes, home-care programs, and mental hospitals, a similar variety is found, but with different ownership and operational configurations. Here, again, the dominant institutional characteristics differ by State and within States.

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¹ *Hospitals*, Guide Issue, part 2, XLI (Aug. 1, 1967).

The differences are more than superficial. Granted, we don't know enough as yet to relate various forms of operation meaningfully to such outputs as morbidity or mortality, but we do know that a given form of operation or ownership is often guarded with more than casual pride. Medical practice differs by area not only because the quality of practice may vary but also because what is considered sound practice varies.

That there is pluralism in the health field should come as no surprise. It is an undistorted reflection of the varying economic, political, and social environment that characterizes the United States as a whole and of the fact that we stand both as a country of neighborhoods and as a nation.

The health-prepayment and -insurance agencies are not exempt from this influence. In 1966, it was estimated that there were over 1,700 agencies providing health benefits (table 1). Their benefit expense totaled over \$9.1 billion. Table 2 contains a rough breakdown of these expenses by type of agency and type of service. To put the number 1,700 in its proper perspective, it should be noted that the vast majority of benefits were administered by 76 Blue Cross and 74 Blue Shield plans, which are strongly associated (approximately 44 percent of all benefits written), and by the 10 largest commercial insurance companies, which write approximately 60 percent of the benefits administered by all insurance companies (approximately 50 percent of all benefits written).

Health-prepayment and -insurance agencies fall into three broad categories: Blue Cross and Blue Shield, commercial insurance companies, and independent plans. Blue Cross and Blue Shield plans are locally incorporated, nonprofit corporations serving the general communities of which they are a part. Some cover an entire State, some a sub-State area. In concert they serve all areas of the United States.

TABLE 1.—*Health insurance carriers*

Type of carrier	Number
Total.....	1,737
Blue Cross plans, 1966.....	175
Blue Shield plans, 1966.....	173
Insurance companies, 1965.....	1,007
Independent plans, 1964.....	582
Community.....	43
Employer-employee-union.....	507
Union-employee welfare fund.....	202
Employer or employee association.....	117
Union.....	17
Employee association.....	74
Employer-employee association.....	97
Medical society.....	2
Private group clinic.....	21
Dental society.....	9

¹ Plus 1 in Puerto Rico.

Source: Louis S. Reed, Office of Research and Statistics, Social Security Administration.

TABLE 2.—Benefit expense of private health insurance organizations, by type of service, 1966

[Amounts in millions]

Type of plan	Total benefit expense		Hospital care		Physician services		Other types of care	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total.....	\$9,141.8	100.0	\$5,993.1	65.6	\$2,831.1	31.0	\$317.6	3.4
Blue Cross-Blue Shield.....	3,975.4	100.0	2,844.0	71.5	1,076.4	27.1	55.0	1.4
Blue Cross.....	2,882.2	100.0	2,778.4	96.4	66.3	2.3	37.5	1.3
Blue Shield.....	1,093.2	100.0	65.6	6.0	1,010.1	92.4	17.5	1.6
Insurance companies.....	4,585.0	100.0	2,911.0	63.5	1,462.0	31.9	212.0	4.6
Group policies.....	3,711.0	100.0	2,288.0	61.7	1,245.0	33.5	178.0	4.8
Individual policies.....	874.0	100.0	623.0	71.3	217.0	24.8	34.0	3.9
Independent plans.....	581.4	100.0	238.1	41.0	292.7	50.3	50.6	8.7
Community.....	218.0	100.0	61.0	28.0	154.0	70.6	3.0	1.4
Employer-employee-union.....	332.7	100.0	175.7	52.8	129.0	38.8	28.0	8.4
Private group clinic.....	12.0	100.0	1.4	11.7	9.7	80.8	.9	7.5
Dental society.....	18.7	100.0	-----	-----	-----	-----	18.7	100.0

Source: Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1940-66," *Social Security Bulletin*, XXX (November 1967), table 13.

Plans are controlled by boards of directors composed of representatives of the public, hospitals, and the medical profession, the proportion varying with the plan. Plans contract with subscribers to deliver service through the medium of contracts directly with, and payment directly to, providers of care. The majority of plans operate under State enabling legislation, which provides for State regulation of financial status and approval of contracts, rates, and methods of payment. Blue Cross plans are subject to standards of approval promulgated by the American Hospital Association. Blue Shield plans must meet standards enunciated by the National Association of Blue Shield plans. National affairs, such as out-of-area benefit payment, transfers, and enrollment of national accounts, are coordinated by active associations, the Blue Cross Association, and the National Association of Blue Shield Plans. Controls over use and costs are worked out directly with providers of care.

Health insurance is written by 676 life companies, 290 casualty companies, and 41 companies offering health and accident insurance only.² Some write group or individual insurance only; the majority write both. Others write only accident or disability policies. The companies are under the direction of private boards. Some are licensed to do business in all States; others confine their activities to one or a few States. Selling takes place most often through local agents who operate on a commission basis. Companies, in essence, contract with clients to pay pre-agreed amounts, or percentages in the event of

² 1966 *Source Book of Health Insurance Data* (New York: Health Insurance Institute, n.d.).

stipulated uses of care. Insurance companies are regulated by State authorities largely in regard to solvency and representations to the public. In design of benefits, the client is involved out of pocket, in all or most episodes of illness, through the media of deductibles, copayment, and indemnities. Most companies are members of the Health Insurance Association of America, which acts in a trade-association capacity in behalf of its constituents.

The vast majority of the 10 million persons enrolled in so-called independent plans were enrolled in community-consumer (approximately 35 percent) or employer-employee-union plans (approximately 57 percent) in 1965. Only 2.8 percent were enrolled in private-group-clinic plans, and 6 percent in dental-society plans.

The community-consumer plans are generally nonprofit plans serving a given area or consumer group. They are controlled by boards of directors representative of the communities involved. All but one of the major plans provide service through group practice. Most provide comprehensive physician service in and out of institution as a distinguishing characteristic. Many plans are members of the Group Health Association of America, which serves as their national spokesman and works to promote their growth and development.

The employer-employee-union plans serve selected groups of employees or union members. They may be operated by welfare funds, employers, employer-benefit associations, or unions. Most are operated by jointly managed welfare funds under Taft-Hartley Act regulations. These plans may provide health benefits directly; i.e., through salaried medical or dental staffs or through payment of, or allowances against, doctor and hospital charges. Characteristically, they cover basic institutional services and physician services to a lesser extent than community-consumer plans, but many experiment with such new benefit areas as dental care, ambulatory drugs, and eyeglasses (sometimes on a basis supplemental to basic benefits written by Blue Cross, Blue Shield, or commercial insurance companies). A third, approximately, provide some benefits through group-practice arrangements.

Private-group-clinic plans are operated by physicians or dentists on a private basis, organized as a partnership or as an association, and offering services to patients on a prepayment basis. They tend to provide comprehensive physician services. Some provide only dental services.

Dental-society plans are essentially the dental-service corporations organized by State dental societies. The plans are nonprofit and provide service benefits on a free-choice-of-dentist basis. Governing boards are composed largely of dentists. Underwriting may be undertaken or it may be passed off to a cooperating institution such as Blue Cross or Blue Shield.

My purpose in citing the characteristics of health-prepayment and -insurance plans is not to identify their well-documented characteristics in detail but, rather, in broad sweeps to portray further the essential diversity as well as the variety of the various methods of financing health services extant in this country. Ranging from Medicare to the Dairymen's Cooperative Creamery of Boise Valley in Caldwell, Idaho, there is represented a broad span of national public policy, local determination, neighborhood prejudice, ownership, operating philosophy, and technique that is unique in the world of health services.

In terms of dollar volume, of the \$26.8 billion spent by consumers on personal health care in 1965, 32.6 percent was met by health prepayment and insurance. In 1950, the percent was 12.1. Over the years a steady growth has taken place.

The ultimate source of funds for health care is the working population. However, expenditures are made through two main channels—private and public. Approximately 75 percent was expended in the private sector in 1965 (table 3), a percentage vis-a-vis the public sector that had remained relatively stable after 1940. Medicare and Medicaid (\$4.9 billion in fiscal year 1967) will, of course, raise the public percentage. At the same time, both programs, through the wide use of intermediaries, have channeled considerable funds through health-prepayment and -insurance agencies, largely on a cost basis, enlarging significantly the responsibilities of these agencies.

How well does the present pattern of private/public financing respond to the challenges of today's environment?

First, what are the challenges?

The major challenge to the present pattern is economic. The core of the problem is rising health-service costs, which come to be reflected in rising premiums or rates, or lesser coverage. These costs are advancing at twice, approximately, the rate of the Consumer Price Index. There is a limit, of course, to the degree over time that expenditures for health care can increase beyond the rise in wages and earnings. In an economy of scarcity, there comes a point when the attractiveness of alternative goods or services exceeds that of health care. As this point is approached, alternatives are purchased and, equally important, pressure is put upon the health establishment to become more productive. A third point of view is sometimes entertained, that is, that health service can somehow be produced without cost, but, fortunately, in most cases that feeling passes.

In the United States we are not at the point referred to above, whatever it is; but as the percentage of the gross national product devoted to health services increases (which it is doing), we know, at least, that we are approaching it. The size of our gross national prod-

TABLE 3.—*National health expenditures by object of expenditure and source of funds, 1965*
[Amounts in millions]

Object of expenditure	Total		Source of funds					
	Amount	Percentage distribution	Private			Public		
			Total	Consumers	Philanthropy	Other	Total	State and local
Total.....	\$40,751	100.0	\$30,534	\$28,074	\$1,459	\$1,001	\$10,217	\$4,955
Health services and supplies.....	37,274	91.5	29,045	28,074	634	338	8,228	4,554
Hospital care.....	13,379	32.8	8,432	8,127	305	—	4,947	2,980
Federal facilities.....	1,600	3.9	15	15	—	—	1,967	19
State and local facilities.....	4,018	9.9	1,352	1,352	—	—	1,566	166
Nongovernmental facilities.....	7,761	19.0	7,065	6,760	305	—	2,666	2,500
Physician services.....	9,003	22.1	8,437	8,428	9	—	235	461
Dentist services.....	2,832	6.9	2,800	2,800	—	—	566	429
Other professional services.....	2,896	2.2	2,842	2,818	—	—	32	14
Drugs and drug sundries.....	4,757	11.7	4,617	4,617	24	—	54	39
Eyeglasses and appliances.....	1,260	3.1	1,219	1,219	—	—	140	69
Nursing-home care.....	1,324	3.2	1,314	1,303	—	—	41	17
Net cost of insurance.....	1,272	3.1	1,272	1,272	21	—	510	24
Medical activities in Federal units other than hospitals.....	868	2.1	—	—	—	—	—	237
Government public health activities.....	947	2.3	—	—	—	—	858	—
Private voluntary health agencies.....	275	.7	275	—	275	—	947	629
School health services.....	133	.3	—	—	—	—	133	—
Industrial implant health services.....	338	.8	338	—	—	338	—	—
Research.....	1,490	3.7	163	—	163	—	1,327	58
Medical facilities construction.....	1,987	4.9	—	—	—	—	—	343
Publicly owned.....	1,655	1.4	1,325	—	662	663	662	319
Privately owned.....	1,432	3.5	1,325	—	662	663	555	223
Percentage distribution by source of funds:							107	96
Total.....	100.0		74.9	68.9	3.6	2.5	25.1	12.9
Health services.....	100.0		77.9	75.3	1.7	.9	22.1	12.2
Research.....	100.0		10.9	—	10.9	—	89.1	3.0
Construction.....	100.0		66.7	—	33.3	33.4	16.1	17.3

Source: Ruth S. Hanft, "National Health Expenditures, 1950-65," *Social Security Bulletin*, XXX (February 1967), table 1.

uct is such that the amount of money channeling into health services has not yet become a major problem, but the growing public interest in productivity is evident. All major purchasers of care, whether management, labor, the Government, or the individual, are actively seeking ways to increase the effectiveness and efficiency of methods of production. Around this core of concern other problems are debated: Is there a shortage of manpower? Do we have enough beds? Despite the militant advocacy behind the concept of shortage, the issues are inevitably clouded by a lack of consensus regarding our present state of productivity. To take an optimistic view, we suffer shortages; short of this mark, we may suffer instead from ineffectiveness. There is enough evidence on the latter side to alert all health institutions, including prepayment and insurance, to action.

Still in an economic context and in regard to prepayment and insurance per se, the market is calling for broader benefits and, among large groups, greater uniformity of delivery across the country. Risk-sharing is viewed as a key defense against costs. The concept of greater uniformity of delivery arises out of a more mobile working population, congregated in larger working groups.

Social forces also must be considered. Without reference to the many underlying factors involved, health has risen on our scale of cultural values. This, of course, does not make it immune from economic forces, but it does tend to accelerate the substitution of community action for market action when the lag between perceived need and availability of service becomes too great. The current cry for "equal access" is symptomatic of this fact. Equal access as an objective is unattainable, if not unsophisticated, but the message is clear: There must be an acceptable minimum of service for all—which is tenable.

The quest for health is highly personal. But we must recognize also that health is a major element in a happy, productive working force and in our fitness as a nation. It is a personal value reinforced, not attenuated, by societal forces.

One other point might be mentioned. Just as the growing number and size of working groups has had economic implications for health prepayment and insurance, the process of urbanization has affected, significantly, people's attitude toward prepayment and insurance, or any health institutions, for that matter. Less imbued with the concept of the self-made, self-sufficient individual, modern urbanized society views organized action as the only plausible defense against the threat of an epidemic and the only means by which the cost of service can be made tolerable. We are in an era that, influenced by the necessities of urbanization, moralizes less and less about essentially financial matters.

Certain output data are also a challenge to be dealt with. For example, as reported by the *New England Journal of Medicine*, longevity has been on a plateau in the United States since 1954, while other countries are moving forward. In 1954, the United States ranked 31st among nations of the world in terms of longevity, down from the 14th position in 1949.³ Not all our children are adequately immunized; too many have never seen a dentist; too many women from poor families lack prenatal care. Not all of these or other facts can be laid on the doorstep of prepayment and insurance. There is, however, enough variation in character and amount of use between insured and noninsured populations and between well-insured and poorly insured populations to challenge responsible carriers to address the problems of benefits and coverage.

Unlike the point of view held by many, that of Government is to face these and other problems in cooperation with prepayment and insurance—not as a challenger of prepayment and insurance. The simple fact that some people cannot afford the level of health services that is now accepted by society as a right for all literally dictates that Government assist the disadvantaged. As it turns out, the amount of money involved can be appreciable. Thus, Government becomes another force interested in how the money is spent. One path chosen by Government in discharging its responsibilities has been, in the image of creative federalism, to contract out services, including those of prepayment and insurance. There are those who feel philosophically that this course is too conservative; others feel that Government should not be in the act at all. In the last analysis, these influences, which play on all national legislative issues, will be of less consequence than whether the job gets done well and with reasonable dispatch.

With reference to this conference, the issue boils down to what can be done to change the present system of financing health services so that its challenges of productivity, access, and effectiveness are met, its strengths are preserved, and its anachronisms are discarded. I should like briefly to explore this question under selected concepts.

Degree of Coverage

The rationale behind the need for widespread health insurance and prepayment can be simply stated. Health expenses are largely unpredictable to an individual. They fall unevenly upon the population. Some families or individuals may face bills of up to 20 percent of their income or more, some none. Such expenses are unrelated to

³ William H. Forbes, "Longevity and Medical Costs," *New England Journal of Medicine*, Vol. 277 (July 13, 1967), p. 78.

ability to pay. Clearly, sharing of experience becomes a logical necessity. How well is our population covered?

Approximately 81 percent of the civilian population had some form of private coverage in 1965 (table 4). The number of persons entitled to, or assured of, care through governmental programs at the end of 1966 can be seen in table 5. Adding this to the number in 1965 (minus an overlap of some 11 million aged who in 1965 had private coverage and in 1966 are counted under Medicare), and relating both to the January 1, 1966, estimated civilian population of 192,920,000, produces the very rough estimate that approximately 90 percent of the civilian population enjoyed some form of protection, either by a carrier, by the Government through the medium of an intermediary, or directly by Government.⁴

Significantly, certain groups of the population are more widely insured by carriers than others. Low-income families enjoy much poorer private coverage than other families (table 6). White persons

TABLE 4.—*Number of persons enrolled by private health insurance organizations, and Health Insurance Association of America estimate of net number of different persons covered, by type of benefit, as of Dec. 31, 1965*

[In thousands, except percents]

Type of plan	Hospital care		Surgical service		Inhospital physician visits	
	Number	Percent	Number	Percent	Number	Percent
Total.....	167,688	100.0	158,730	100.0	119,345	100.0
Blue Cross-Blue Shield plans.....	63,662	38.0	56,330	35.5	53,119	44.5
Blue Cross.....	61,651	36.8	3,660	2.3	13,610	3.0
Blue Shield.....	2,012	1.2	52,669	33.2	149,509	41.5
Insurance companies:						
Net total ¹	97,042	57.9	93,717	59.0	58,398	48.9
Unadjusted total.....	108,524	-----	104,402	-----	63,191	-----
Group policies.....	67,104	-----	67,557	-----	50,632	-----
Individual policies.....	41,420	-----	36,845	-----	12,559	-----
Independent plans.....	6,984	4.2	8,684	5.5	7,828	6.6
Community.....	1,954	1.2	3,400	2.1	3,388	2.8
Employer-employee-union.....	4,971	3.0	5,068	3.2	4,187	3.5
Medical society.....	8	(³)	10	(³)	10	(³)
Private group clinic.....	51	(³)	206	.1	243	.2
HIAA estimate:						
Net number of different persons covered.....	156,047	-----	145,938	-----	112,808	-----
Percent of civilian population ⁴	80.9	-----	75.6	-----	58.5	-----

¹ Estimated.

² Number of different persons covered, after deduction for those covered by more than 1 insurance policy.

³ Less than 0.05 percent.

⁴ Based on estimated civilian population (192,920,000) as of Jan. 1, 1966.

Source: Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1965," *Social Security Bulletin*, XXIX (November 1966), table 1.

⁴ Ninety percent can be considered only a crude estimate. Table 5 is based on a broad assumption, as stated in the footnote 3. Both the private-coverage and population data would have to be updated to the end of 1966 to make the ratio consistent. It should be said that both are increasing in step; thus, this error could be small.

TABLE 5.—Number of persons entitled to or assured of care through governmental programs, end of 1966

[In thousands]

Program	Hospital care	Physician services
Total.....	29,975	28,875
Medicare ¹	18,600	17,500
Military dependents and retired military personnel ¹	3,841	3,841
Seamen ¹	123	123
Public assistance: ²		
Old-age assistance.....	2,073	2,073
Aid to the blind.....	84	84
Aid to the permanently and totally disabled.....	588	588
Aid to families with dependent children.....	4,666	4,666
Medical assistance (Medicaid) ³	(3)	(3)

¹ Data from Office of Research and Statistics, Social Security Administration.² Data from *Social Security Bulletin*, XXX (April 1967), table M-18.³ The number of people assured of care under Medicaid cannot be estimated since in most States persons are determined to be eligible only upon application after having incurred medical charges that they cannot meet. Hence, the number of persons receiving cash grants under public assistance is the best measure of the number of persons assured of care through welfare programs. However, there is an overlap between Medicare and Medicaid. About 1.1 million old-age assistance recipients are social security beneficiaries.

have far better coverage than nonwhites. Employed persons are more widely insured than unemployed persons. Farm laborers and low-skill workers have less coverage than others. And greater rurality is associated with lesser coverage.

The Government programs, particularly with the advent of Medicaid, tend to even out the variation in the private market. The adequacy of the breadth of coverage, without reference to depth at the moment, is under debate. There are a few who resist coverage or care for religious or other reasons. Beyond these, the two main points of debate are whether the totally and permanently disabled should receive hospital benefits under Medicare,⁵ and, more significant numerically, where the line of medical indigence should be drawn under Medicaid.⁶

Where the line is drawn will vary by State, but present indications are that the potential of the private market is somewhat near 80 percent of the civilian population, and Government, near 20 percent of the population. This presupposes a small expansion of Medicare to embrace such persons as the permanently and totally disabled and an expansion of Medicaid to include the medically indigent not under public assistance at any given moment and not shown on table 5. The Congress is currently considering a rather strict definition of medical

⁵ Part A: "Hospital Insurance Benefits for the Aged" of Title XVIII of the Social Security Act: "Health Insurance for the Aged."

⁶ Title XIX of the Social Security Act: "Grants to States for Medical Assistance Programs."

TABLE 6.—Selected characteristics of persons with health insurance, July 1962–June 1963

Characteristic	Percent of persons with—	
	Hospital insurance	Surgical insurance
Family income:		
All persons.....	70.3	65.2
Under \$2,000.....	34.1	28.8
\$2,000-3,999.....	51.9	46.8
\$4,000-6,999.....	79.0	73.9
\$7,000-9,000.....	87.3	83.2
\$10,000 and over.....	87.9	82.6
Race:		
White.....	73.6	68.5
Nonwhite.....	45.5	40.2
Residence:		
Urban.....	74.5	69.2
Rural nonfarm.....	63.8	59.2
Rural farm.....	50.8	46.6
All persons in the labor force.....	76.4	71.0
Employment status:		
Employed.....	77.7	72.3
Unemployed.....	50.8	45.8
Occupation: ¹		
Professional workers and managers.....	84.2	78.6
Clerical and sales workers.....	84.8	79.3
Farmers and farm managers.....	74.3	69.3
Operatives and service workers.....	75.3	69.9
Farm laborers.....	27.3	23.5
Private household workers.....	51.4	45.3
Laborers, except farm and mine.....	59.7	54.5
Other occupations.....	55.3	48.7

¹ Includes both employed and unemployed persons.

Source: U.S. National Center for Health Statistics, *Health Insurance Coverage, United States, July 1962–June 1963*, Series 10, No. 11 (Washington: U.S. Government Printing Office, 1964), tables 3, 10, 16.

indigence. A more liberal definition in the future could result in a private/Government market ratio of 75 : 25.

Predictions in regard to Medicaid are hazardous. "Need" for food, clothing, and shelter, and other needs, such as medical needs, are based on State estimates. Each State determines its own needs. Further, Federal law does not require that assistance payments meet full "needs," and many States place arbitrary limits on the amount of assistance that can actually be paid, which can be lower than the minimum need established. In January 1967, the percent of need met for recipients of Old Age Assistance varied by State between 45 percent and 100 percent (37 States). At the same time, the percent of need met for recipients of Aid to Families with Dependent Children varied by State between 22.8 percent and 100 percent (22 States). Under a provision in the proposed Social Security Amendments of 1967 (HR 12080), Federal participation in Medicaid is limited to individuals and families whose income is less than 133 percent of the highest amount ordinarily paid a family of similar size under the Aid to Families With Dependent Children programs. Whereas it is safe to

predict that all States will have Medicaid programs by 1970, the total number included under the program is subject to varying State concepts of need and varying degrees of willingness or ability to supply funds to meet this need. Given a broad and emerging consensus about access to care, it appears as though the boundary between private and public coverage will vary largely with the economic well-being of an area, or the country as a whole, with greater accent on public assistance during times of depression—assuming that the Federal social insurance program remains focused on the problems unique to specific age and disability categories.

Purchasing power is the key to coverage, and, between public and private effort, we seem on the verge of meeting this problem. In this regard, carriers can play a somewhat limited but nevertheless important role. It is possible, through design of rating, through pooling and subsidy, to assist the less fortunate or, through precise experience-rating, to heighten the problems of the less fortunate. It is well to recall that in every group there are those who, through the individually uncontrollable accidents of occupation, sex, age, disease, or group size, experience more than average need for service. For a carrier to probe assiduously among groups in an effort to screen out groups with a disproportionate share of hazardous occupations or groups with an advanced average age, in the name of incentive, may seem commercially astute, but it lacks, critically, relevance to the problem. Provision should be made by all reasonable carriers to combine groups fortuitously susceptible to high use with other groups and, further, to charge all classes of risk a surcharge that, as a pool, can be drawn upon to even the course of the less advantaged during any given year or over the years.

Individual coverage poses special problems. Carriers should make every effort to recognize and form special groups—e.g., associations, clubs, neighborhood groups—so that persons who cannot be reached through employee groups can be offered the opportunity of enrollment on advantageous terms.

Purchasing power is critical, but it is not the only ingredient to be considered. Are broad benefits readily available for those who want them? Most reputable carriers do not resist the idea of offering a high level of benefits. Many, however, could package their products more effectively; benefits that lack simplicity, are hard to understand, or require excessive paperwork in order to effect a claim are not conducive to initial purchase or intelligent use. Policies that have excessive waiting periods or exclusions, reduce benefits for dependents, or use elaborate cancellation clauses inevitably discriminate against the unfortunate rather than build character among the fortunate. Their only

redeeming value seems to be the carrier's reserve. From the point of view of the individual or the family, they hardly elicit confidence in coverage.

To strengthen coverage, the following steps are recommended:

1. Carriers should assist the fortuitously less advantaged to obtain coverage through such devices as pooling of risks, subsidy, and innovations in enrollment techniques, i.e., the creation of special, or "fictitious" groups. Individual-carrier resolve should be strengthened by associated action among carriers.

2. Similarly, the less advantaged should be assisted to use and maintain coverage through such devices as simplicity of contract language, simplicity of claims administration, minimal limitations, non-cancellation clauses, and a guaranteed right to transfer from group to nongroup coverage and have such coverage fully portable. Associations of carriers, again, should work on prototype methods and language.

3. Associations of carriers must seek to raise standards of membership and strengthen programs of internal research and education. Currently, there are too many carriers to render benefits efficiently. Survival too often depends on sharp underwriting and movement in and out of accounts or among individuals, in quest of low loss ratios. This type of competition has the odd effect of reducing the quality of the product while not meeting the customer's problem. Fewer, larger, more stable carriers should be able to respond to a higher sense of professionalism and have sufficient financial integrity to avoid sharp practices and expediciencies.

4. A more precise concept of need for the basic elements of food, clothing, shelter, and medical care is needed, based on more methodical and more interdisciplinary research than has been undertaken to date. Given this, Federal participation in health programs for the indigent or medically indigent should be based on the implementation of a minimum program of eligibility, adapted in dollar terms to the price index of a given State. In the light of a renewed emphasis on keeping people well through meaningful employment, provision should be made for reasonably easy access to and egress from such a program.

5. State government should focus on the problem of the temporarily unemployed as a special category of indigence, making it possible, with partial aid from employer contribution, to carry coverage through periods of economic adjustment.

Scope of Benefits

Often overlooked is the fact that the rationale behind some coverage, discussed under the previous section, applies to all elements of the medical-care dollar—not just to those services that historically were covered earliest. Health prepayment and insurance have too long focused on the hospital, for example. To a given individual, ambulatory services or drugs might well be equally difficult items of expense.

Such items, singly, might be significantly less expensive than a hospital stay by comparison, but their cumulative effect can be damaging.

How well covered are the various elements of the medical-care dollar? Equally as important as breadth of coverage is its depth. It should be said straightaway that—with all the various plans we have—probably no one prepayment plan covers all health services, that is, hospital care, physician care, necessary nursing service in the hospital and home, care in convalescent facilities and nursing homes, dental care, drugs, eyeglasses, appliances, and ambulance service.

Among those in the civilian population with some private coverage, hospital care and surgery predominate (table 4). These services were the first focus of health prepayment and insurance. Inhospital medical visits as a category follows closely behind. In regard to all other types of services, a considerably smaller percentage of the civilian population is covered. Dental-care and nursing-home-care benefits are conspicuously light.

When Medicare and Medicaid are considered, the percentages move up. Under Medicare, the expenses of hospital care, surgery, inhospital medical visits, home and office visits, ambulatory diagnostic services, home care, and nursing-home care are fairly well covered. Under Medicaid, almost all medical expenses can be covered, although the precise degree will vary by State.

It should be noted that the vast majority of people who were covered by private benefits before Medicare have purchased complementary coverage. It is estimated that approximately 60 percent of all aged persons have such coverage or are eligible for State medical assistance. In large degree, complementary contracts fill deductible and coinsurance provisions. Beyond this, the benefits vary considerably with the contract.

The overall percentage of consumer expenditures met by private prepayment and insurance has increased measurably over the years, as has been mentioned; in 1965 it was 32.6 percent (table 7). Notably, whereas hospital care and physician services were quite well and fairly well covered, respectively, other services were not. However, behind these figures one sees active ferment. Coverage of hospital days is being extended, and inhospital mental benefits are being given increasingly equal standing. Physicians' fees are being met to a greater extent under so-called usual and customary fee contracts. Pacesetting, large accounts are moving into such areas as outpatient psychiatric care, group therapy, psychological testing, extended care, and pre- and postnatal care. And, as has been mentioned, various independent plans have moved into such new areas as vision care and ambulatory drugs, often on top of a broad base. The number of dental-service

TABLE 7.—Amount and percent of personal health care expenditures and consumer expenditures for medical care met by private insurance, selected years, 1950–65

[Amounts in millions]

Type of service and year	Personal health care expenditure	Consumer expenditure for personal health care		Insurance payments		
		Amount	Percent	Amount	As percent of—	
					Personal health care	Consumer expenditure
All types of services:						
1950.....	\$11,069	\$8,201	74.1	\$992	9.0	12.1
1955.....	15,837	11,807	74.6	2,536	16.0	21.5
1960.....	23,515	18,066	76.8	4,996	21.2	27.7
1965.....	34,781	26,802	77.1	8,729	25.1	32.6
Hospital care: ¹						
1950.....	3,845	1,965	51.1	680	17.7	34.6
1955.....	5,929	3,244	54.7	1,679	28.3	51.8
1960.....	9,044	5,281	58.4	3,304	36.5	62.6
1965.....	13,379	8,127	60.7	5,790	43.3	71.2
Physician services: ¹						
1950.....	2,755	2,597	94.3	312	11.3	12.0
1955.....	3,680	3,433	93.3	857	23.3	25.0
1960.....	5,684	5,304	93.3	1,593	28.0	30.0
1965.....	9,003	8,428	93.6	2,680	29.8	31.8
Other:						
1950.....	4,469	3,639	81.4	(²)	(²)	(²)
1955.....	6,228	5,130	82.4	(²)	(²)	(²)
1960.....	8,787	7,481	85.1	99	1.1	1.3
1965.....	12,398	10,247	82.6	259	2.1	2.5

¹ Includes insurance payments of small amounts for other types of professional services for 1950 and 1955.² Data not available.Source: Ruth S. Hanft, "National Health Expenditures, 1950–65," *Social Security Bulletin*, XXX (February 1967), table 7.

corporations has grown significantly in the last few years. Several large accounts have purchased dental benefits on the west coast, and interest is growing throughout the country.

Evidence of consumer interest in broader benefits can be seen in the Federal Employees Health Benefits Program, where, in a choice situation and with a constant-dollar assist from the Government, 87 percent of the employees under the Governmentwide service-benefit program selected the significantly more expensive high-option program over the low-option program. In one large company, prior to employer contribution, 91 percent of all employees selected the best program available from among all options. Again, we see the vast majority of aged persons supplementing their Medicare program.

Behind some of the interest lies greater employer contribution under group contracts, but, basically, there lies a growing appreciation of the need for protection against the cost of an expanding armamentarium of health services.

How much of the medical-care dollar should be covered? Excluding nonprescription drugs, cosmetic elements, and various nonessentials from the concept of the medical-care dollar, probably we will and

should approach 80 percent before the 1970's are very old. This means that prepayment and insurance will more than double their benefits, assuming today's services and prices. Something short of 100-percent coverage will result from the fact that there will always be a lagtime under new and experimental services, and the cost of administering some of the small, often repetitive expenses can exceed their value to the individual.

We should see growth stimulated significantly by collective bargaining and Government financing. It is essential that health prepayment and insurance anticipate this and work now on what kind of package to offer. Major medical coverage is not the answer. Comprehensive benefits must be designed not only to protect the consumer adequately and result in enough payment to stimulate growth of health services, but also promote, by their structure, effectiveness of care. For example, to offer a nursing-home benefit without regard to how and under what conditions the services relate to the general hospital is not sound benefit-planning. Similarly, an ambulatory-drug program should have some point of view toward what drugs are coverable (e.g., all drugs, prescribed drugs, legend drugs, generic drugs), whether they can be dispensed in doctors' offices, and whether they should be paid for on a service (cost of drug plus dispensing fee) or indemnity basis. The development of benefits that enrich the traditional hospital benefits will take research (market, professional, etc.) and planning in depth by carriers, but it must be done. When a fringe benefit is finally decided upon at the bargaining table, it is too late to start planning en masse. Too few carriers are geared for research and development work. Rarely is so much money processed among American institutions on the basis of so little research and development. A sound benefit is a function of what people want and can comprehend, what is professionally sound or possible, and what is economically feasible. None can be fathomed well from an executive's or salesman's desk.

To strengthen the scope of benefits, the following steps are recommended:

1. Carriers should engage in more research in the development of benefits. A multitude of professional and market questions should be identified and balanced. At the very least, the new benefit should do no harm, and hopefully should improve service to the patient and be substitutive as often as additive. Importantly, new benefits should be prepackaged and properly integrated with the benefit core so that the consumer could examine his choice before purchase on the basis of fact rather than speculation.

2. Thought should be given to building some flexibility into benefit structures, so that the needs of the individual as well as those of the group could be met more effectively within a given actuarial value.

3. In some States, employers, particularly medium to small employers, do little to assist their employees to avail themselves of coverage, either through contribution or encouragement to participate. If this situation persists, either as an attitude or phenomenon of marginal business activity or as an unenlightened way of obtaining a competitive price edge, thought should be given to inducements to stimulate a minimum level of employer participation.

4. Increasingly, some new services will cost prodigious amounts of money during the early stages of their development and almost experimental use, which will continue to be financed largely by Government, as in the past. A more orderly basis for transferring fiscal responsibility from experimental maintenance to financing use through prepayment or insurance needs to be developed.

Controls of Use and Costs

A major decision to be made by health prepayment and insurance is what their responsibility is with regard to the use and costs of health services.⁷ Do carriers simply exchange money with subscribers and invest reserves judiciously, or are they a more integral part of the health-care system?

At the root of the decision is whether the services paid for are sufficiently competitive and sufficiently measurable—so that regulation is relatively automatic and quality reasonably identifiable—or not. A sound argument can be set for that they are not. In the health field, providers are not fully competitive; consumers are hardly knowledgeable and, in fact, often have no choice but to get care; there is lack of consensus on need versus demand as an animating force, and there is no one criterion of success, such as profit. The basic elements of a free market are so severely compromised that substitute controls must be found.

“One cannot adopt the easygoing assumption that hospitals, allied institutions, doctors, etc., will automatically array themselves in a tight, orderly fashion. . . .

“Of course, there is no such thing as a perfectly free market in any sector of our economy. It is a relative concept. In our modern society, many segments of our economy are subject to regulation and other nonmarket forces. Clearly, the health economy falls in this category. If full-scale economy is to be achieved, it must be consciously sought through planned programs.

“The issue at stake is who exercises what controls. Certainly, among other agencies, prepayment has a role to play. If it ever was, it is no longer enough for the typical carrier to help generate purchasing

⁷ For a fuller treatment of this important topic of controls of use and costs, see Walter J. McNerney, “Toward More Efficient Systems,” *Report of the National Conference on Medical Costs, Washington, D.C., June 27–28, 1967* (Washington: U.S. Government Printing Office, 1968) pp. 296–314.

power or to trade money. It must carry beyond this point to discriminate purchasing. This is the sign of the future for prepayment—ranking in importance with the absolute requirements for growth in benefits and coverage.

“To date, the adoption of control responsibilities by carriers varies considerably, both among carriers and in respect to what could be done. Some have fairly creditable records. Regrettably, some have shown little interest in the subject at all or, worse, pay it only polite lip service”.⁸

Furthermore, the types of controls vary. Popular with commercial carriers are such devices as indemnity, deductibles, and coinsurance. The purpose of the first two is to screen out some health expenses altogether. All three are designed to maintain the active interest of the insured individual in monitoring the services rendered him, in regard to both quality and quantity. The problem arises that if the deductible, and other, amounts are limited, their impact on use is not measurable. If they are large enough to affect use they run the danger of creating underuse and subscriber dissatisfaction. Their inherent weakness stems from the fact that the individual consumer is in a poor position to judge or influence quality or quantity of care. Their main applicability appears to be to small, repetitive expenses, where the cost of administering each claim separately could become excessive. Also, they do keep the premiums down, if this is one's objective.

The above devices are generally accompanied by experience-rating, under the thesis that a group credited purely with its own experience will have an incentive to improve when its cost experiences rise above the “average.” As has been mentioned, some groups—because of age, sex, size, occupational, or geographical characteristics unrelated to promiscuous use—are penalized by this process. The economic quest for a low loss ratio is apt to leave a large social problem of poor coverage for some in its wake. Also, one must ask, how sound is the premise that management and labor will work, together or separately, in a given plant, to influence the building and distribution of health facilities or the professions that use them? Rating should be animated by a social as well as an economic strategy.

The carrier that performs essentially a reinsurance role, leaving to a given group the substantive functions of eligibility determination, claims administration, provider payment, etc., abdicates its control role completely. Under these circumstances, can we expect most employers to tackle either the ineffective use patterns of the professional community or those of a valued employee? Can any industry or group afford the variety of skills necessary to play the role of carrier to its fullest potential?

What kinds of controls need to be exploited?

⁸ Ibid, pp. 297-8.

REIMBURSEMENT FORMULAS

Payment of uncontrolled charges or costs to health institutions in a noncompetitive setting cannot be defended. Some controls must be built in by the carriers that pay providers directly. Among those that have been used or suggested are the payment of periodically negotiated and audited costs, payment of controlled charges, per capita payment, or built-in incentives to reduce costs. Further experimentation with these and other devices and combinations is needed.

Similarly, payments to physicians must be made with due regard to customary and prevailing fees, or through a carefully negotiated fee schedule on a service basis, or by negotiated per capita payments. Needless to say, the method of payment cannot stand alone as an effective tool. Perhaps it can establish some useful parameters and possibly some incentives, but it needs a frame of reference if quality and system are to be preserved among providers of care.

REFERENCE TO OUTSIDE CRITERIA

Areawide planning.—Automatic or guaranteed regeneration of capital cannot be defended in any economic setting. The right to survival and growth must be related to some measure of demand or need. Given the nature of the health economy, health prepayment and insurance must throw their full weight behind areawide planning of health institutions (data, skills, leadership, and funds) and, for those that pay providers directly, make payment of capital conditional upon eligibility under the planning mechanism.

JCAH⁹ status.—As accreditation strengthens, carriers that pay providers directly should consider nonpayment or lesser payment to unaccredited institutions, with exceptions for the sake of availability of health services determined only at the highest policymaking level.

Practitioner status.—At least modest efforts should be made to explore the recognition of specialized skills in payment. Perhaps incentive payments could be made to physicians moving into understaffed areas.

CLAIMS ADMINISTRATION

Too often a perfunctory process, claims administration can become a useful control. Payment should be related to the contract between the carrier and the patient; beyond this, modern electronic-data-processing technology makes it possible to develop parameters based on wide knowledge of use patterns under specific age, sex, and diagnostic

⁹ Joint Commission on Accreditation of Hospitals.

situations, outside of which, care can be evaluated by professional teams and questions can be asked of providers.

UTILIZATION REVIEW

Carriers should work with providers to establish utilization-review committees and, once they are in operation, strengthen these committees through supplying organized use data, classified by hospital, doctor, diagnosis, etc., to enlarge considerably the background against which judgments are made by the committee. Carriers can help develop formats and procedures, drawing upon their experience with a wide variety of institutions. Referrals can be made on the basis of analyses derived from the claims-administration process. And, in the final analysis, economic sanctions can be applied in making payment, to support the work of the committee.

RECERTIFICATION

Carriers can ask for physician recertification on longer-stay cases, either citing a given series of checkpoints (14th day, 21st day, etc.) for all diagnoses or relating the checkpoint to the diagnosis involved. In any event, a forceful reminder is established as to whether the care is economically as well as clinically sound.

BREADTH OF BENEFITS

Broad benefits are not only a market necessity; they are, potentially, a useful control. The physician should have a wide variety of prepaid benefits at his disposal so that referrals can be made without prejudice as to how benefits apply. In today's market, for example, the focus on hospital benefits invites excessive use of this type of expensive care.

Mobility among services is, of course, not the whole story. How are these services organized? In this regard, the carrier needs to be alert to differences in the use patterns among the several forms of medical practice, ranging from solo practice through various forms of associated practice, such as comprehensive group practice, and between loosely structured and tightly structured preventive-treatment and rehabilitative services. Further, the carrier needs to help set up and evaluate experiments with the various patterns to which prepayment is sensitively keyed.

DUPLICATION OF BENEFITS

Whenever cash is paid to a consumer for health benefits, the situation has to be watched. The concept of primary and secondary payment among carriers needs to be improved.

EDUCATION

The end products of education are hard to measure, but it is important that carriers exploit their considerable knowledge of use and cost patterns to point the way for subscribers toward intelligent use of health facilities. Also, carriers can assist providers and professionals to understand the pressures of the market. It is extremely important that the prejudices and demands of the buyer and seller of services not be insulated by a passive carrier.

The proper employment of the above controls is tricky at best. The number of variables affecting use, cost, and quality is great and their interaction is complex. No one control is sufficient in itself. Carriers must start to employ a variety of controls, evaluating each methodically, cognizant that carrier control must always be related sensitively to the total matrix of controls exerted by providers, professional organizations, and Government.

There are three major impediments to the fuller exploitation of carrier control. First, some carriers view themselves as fiduciary institutions that should take no action that can be construed as interfering with the professional decisions or the administration of health services; further, whatever the types and amounts of coverage desired, they are made available. This view, coupled with the use of strict experience-rating and continuous involvement of the patient in paying through indemnity, etc., has the effect of placing the responsibility for control almost totally in the subscriber's and provider's hands. If weaknesses develop, they will be corrected—somehow—by the competition of a multiplicity of insuring organizations, vying with one another in a free marketing system. This view puts a high value on freedom—freedom of inquiry, method, and experimentation—except as it might apply to freedom to experiment with controls methods.

Second, some providers and professionals resist a linkage of carrier and provider control activity. Any outside rationalization of demand or need is viewed as interference with quality of care. Carriers, of course, must be highly sensitive to qualitative factors and equally sensitive to the danger of underfinancing health services, but we are beyond the day that any party to the provision or financing of health services can fail to exploit his particular advantage in reaching toward an intelligent use of scarce resources, as well as toward an intelligent application of a dynamic medical science.

Third, it is true that we know little about some aspects of use or quality, and this should be a brake on overenthusiasm. But we have developed some useful techniques and methods, and these should be pursued while we push on to improve our understanding.

In regard to controls, the following steps are recommended:

1. Carriers should not rationalize the economic effectiveness of an ill, fearful, and unsophisticated subscriber in controlling health services, or overestimate the effectiveness of a given group in articulating its concerns over the provision of health services, but, rather, accept the need to play a substantive role in the controls affecting the use and costs of health services.

2. Carriers should engage in research to improve control techniques, whether in the form of direct interventions such as recertification or through incentives. In these efforts, carriers should seek the full cooperation of providers. In order to be effective, a control cannot unwittingly reduce the quality of care while focusing on quantitative considerations.

3. Carriers should seek out the natural variation that exists in the United States in the manner of delivering health service and evaluate the differences. Are some forms of practice more effective than others? It would be well, too, for carriers to set up demonstration units. This can be a far better use for reserves than a preoccupation with yields.

Administrative Efficiency

The carrier can have his greatest impact on costs of health services by working with providers. However, another element in the overall cost of health services is their own administrative expense. How much does it cost the carrier to perform his functions? Or, to put it another way, of every dollar spent by a subscriber availing himself of protection, how much does he get back in the form of benefits?

Retentions vary considerably by broad categories of carriers (table 8). Some of the variation is due to the manner of doing business, for instance, payments of dividends to stockholders or not, commissions versus salary for the sales force, payment of taxes or not, the mix of group versus nongroup business, or the relative amounts of medical as opposed to hospital claims.

Also, there is considerable variation within categories. In 1962, the ratio of expenses to premiums after dividends for the 50 largest writers of group accident and health insurance ranged from 0.5 percent to 34.5 percent. The variation was wide even within size categories. In the same year, the ratio of expenses to premiums earned for the 50 largest writers of individual accident and health insurance ranged from 28.8 percent to 71 percent.¹⁰ Again, variation was extensive within size categories.

Among all the Blue Cross plans in the United States in 1965, operating expenses ranged from 1.7 percent to 11.3 percent of earned subscription income for group and nongroup hospital benefits. In 1965,

¹⁰ Louis S. Reed, *Financial Experience of Health Insurance Organizations in the United States*, Social Security Administration Research Report No. 12 (Washington: U.S. Government Printing Office, 1966).

the ratio of operating expense to subscription income for all Blue Shield plans in the United States ranged from 4.4 percent to 18.4 percent for group and nongroup medical-surgical benefits. Information on individual independent plans was not obtained, but the variation among classes can be seen (table 8).

In viewing these data, it must be kept in mind that retentions can be too low as well as too high. Once expenses are cut below a certain point, it is no longer possible for the carrier to exercise a full scope of administrative activity. Unfortunately, we lack data on what a reasonable range of expense should be for various classes of benefits, but with all of that, the variation must be considered excessive.

Dividends might average from 1 to 2 percentage points; taxes, licenses, and fees might average 2 to 3 points; and the difference between the cost of administering medical-surgical and hospital benefits might be of the order of 5 to 10 points; classifying business by group and nongroup balances out this consideration. The differences exceed these magnitudes considerably. Any system of delivery of benefits that retains almost half the premium income is not sufficiently productive to warrant subscriber support (see table 8). The marketing of benefits to individuals through a system of agents that is so costly suggests either excessive commissions or an inefficient system, or both. Granted, individual subscribers are harder to reach than group subscribers and more costly to maintain, but there comes a point when one should review the whole concept of delivery of benefits.

The variation within broad categories, that is, by company, suggests that some companies are rubberstamping claims and others are spending too much money on administration. Net underwriting gain is not impressive, on the average. It appears as though intense competition among carriers had resulted in stimulating underwriting gain, but had not had a leveling effect on administrative performance. This is a weakness because, again, administrative performance is the key to the carrier's role. Unfortunately, these analyses are obfuscated by the fact that multiline companies can and do subsidize given lines of business with other lines.

In regard to administrative efficiency, the following steps are recommended:

1. Research should be undertaken to update what we know about retentions, related to specific companies and to output.
2. Efforts should be made to develop reasonable ranges of retentions, by category of carrier, for specific lines of business, which can serve as useful reference points for consumers and insurance commissioners.
3. Particular attention should be paid, during inquiry, to the efficiency of a system of individual agents and the effectiveness of a myriad of small companies as measured against the substantive role

TABLE 8.—*Financial experience of private health insurance organizations, 1966*
[Amounts in millions]

Type of plan	Total income	Subscrip- tion of premium income	Claims expense		Operating expense		Net underwriting gain		Net income	
			Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of total income
Total.....	(1)	\$10,564.1	\$9,141.8	86.5	\$1,517.2	14.4	-\$94.9	-0.9	(1)	(1)
Blue Cross-Blue Shield.....	\$4,394.4	4,327.8	3,975.4	91.9	272.8	6.3	79.6	1.8	\$146.2	3.3
Blue Cross.....	3,132.6	3,085.9	2,882.2	93.4	152.3	4.9	52.3	1.7	99.0	3.2
Blue Shield.....	1,261.8	1,241.9	1,093.2	88.0	120.5	9.7	27.3	2.2	47.2	3.7
Insurance companies.....	(1)	5,595.0	4,585.0	81.9	1,205.0	21.5	-195.0	-3.5	(1)	(1)
Group policies.....	(1)	3,987.0	3,711.0	93.1	510.0	12.8	-234.0	-5.9	(1)	(1)
Individual policies.....	(1)	1,608.0	874.0	54.4	695.0	43.2	39.0	2.4	(1)	(1)
Independent plans.....	641.3	641.3	581.4	90.7	39.4	6.1	20.5	3.2	20.5	3.2
Community.....	237.0	237.0	218.0	92.0	17.0	7.2	2.0	.8	2.0	.8
Employer-employee-union.....	370.7	370.7	332.7	89.8	20.0	5.4	18.0	4.8	18.0	4.8
Private group clinic.....	13.6	13.6	12.0	88.5	1.2	8.6	.4	2.9	.4	2.9
Dental society.....	20.0	20.0	18.7	93.5	1.2	6.0	.1	.5	.1	.5

¹ Data not available.

Source: Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1940-66," *Social Security Bulletin*, XXX (November 1967), table 11.

portrayed in the previous section. Too often, neither is geared to do a professional job of consultation or advice.

4. The time is here for a Flexner Report on health prepayment and insurance. There are many signs of sound performance, but enough countersigns to warrant a professional survey under the auspices of a major foundation.

Regulation of Carriers

Like other corporations clothed in the public interest, carriers are subject to various legal and professional regulations.

PROFESSIONAL ASSOCIATIONS

Commercial carriers have established several associations. The Health Insurance Association of America was organized in 1956 to carry forward the work of two previous associations that had dealt with interchange of statistics, development of manuals, standardization of policy provisions, controls over fraudulent practices, and legislation. The Health Insurance Institute is the public-relations arm of the Association. It works with the Health Insurance Council in public relations and educational activities directed to hospitals and doctors. Agents are organized through the International Association of Health Underwriters and the National Association of Life Underwriters; the former prescribes a code of ethics and both engage in educational activities. Beyond these, there are such educational organizations as the American College of Life Underwriters and such professional associations as the Society of Actuaries.

All Blue Cross plans are members of the Blue Cross Association, which conducts research and educational programs and acts to coordinate and upgrade plan performance. Also, plans are subject to approval by the American Hospital Association. Similarly, Blue Shield plans have their association, the National Association of Blue Shield Plans.

Independent plans have various rallying points. Group-practice plans meet under the auspices of the Group Health Association of America. Employer/employee-plan personnel are active in the National Foundation of Health, Welfare and Pension Plans. Dental-society plans are members of the National Association of Dental Service Plans, a newly formed association.

All associations must be given credit for major efforts to improve carrier performance through education, research, and the development of prototypes. However, their authority is derived from the institutional membership, and is largely without direct public influence. Such authority is often reluctantly given. As a result, compliance by individual carriers is largely voluntary, and most activities depend

for success, in the last analysis, upon someone's sense of gain or morality.

Most carriers have underexploited the potentials of their associations. To the extent that sound operating procedures and regulations are established at this level, less outside regulation is needed. There is considerable room for strengthening the educational, research, and standard-setting functions of associations. The main question that hangs in abeyance is whether the constituents are sophisticated enough to sense the need to move with the times.

GOVERNMENTAL REGULATION

Commercial carriers.—The focus of the regulation of commercial carriers is at the State level, through commissioners of insurance. In general, commissioners are empowered by law to enforce regulations concerning incorporation, rights of out-of-State companies, standards of solvency, adequacy of reserves, investments, liquidation, periodic reports and examinations, qualifications of agents and brokers, policy language, expense ratios, and rates. Other laws deal with misleading advertising and standards of competition. The commissioners meet semiannually as members of the National Association of Insurance Commissioners to share experiences and develop recommendations for improved practices. This organization has no legal authority, but it has sponsored uniform laws, adopted in many States.

It is not difficult in most States for either a life or a casualty company to obtain a license to write health benefits on a multiline basis or to establish a single-line health company. All States regulate policy forms for individual health insurance to some extent. Some requirements are stipulated by law; others are optional. Most States regulate group-policy forms. California law, since 1951, provides that "irrespective of the premium charged . . . any benefit . . . or the benefits of the policy as a whole [must be] of real economic value to the insured." Some laws contain a provision concerning the reasonableness of the benefits in relation to the premium charged. Laws vary in regard to misleading or obscure provisions and sales or advertising methods.

On the thesis that health policies are so heterogeneous and competition so intense among carriers, insurance-company rates are not regulated per se, although in a majority of States they must be filed. Out-of-State insurers have been difficult to regulate, particularly if they operate only by mail, which is subject to censor largely only on the basis of fraud or deception. Steps have been taken, but nothing can substitute for sound legislation and regulation in the home State.

There are special provisions for group policies, varying by State,

dealing with minimum group size and the types of groups that can be enrolled. Some carriers have been questioned on rates that are excessively low in relation to the risk involved.

Some States have imposed limits on the ability of carriers to cancel policies. Various notice periods are stipulated. New York has prohibited cancellation for health reasons and made conversion from group to individual coverage mandatory without evidence of insurability; a similar right is preserved for family members who wish to purchase individual policies.

Prepayment.—The majority of Blue Cross and Blue Shield plans operate under special State enabling legislation, which sets up separate, special provisions for regulation by a State agency, usually the insurance department. The degree and mode of regulation vary by State, but regulation usually embraces financial status and approval of contracts and rates. In some cases, rates of payment to providers must be approved. Most laws stipulate in general terms what the composition of the board of directors must be.

In several highly populated States the approvals are searching. Public hearings are held, and all issues and points of view widely aired, prior to approval.

Independent plans are hard to classify. Some operate under the same enabling legislation as that for Blue Cross or Blue Shield and are subject to similar regulation. Others are not subject to any particularly formalized State control. There are few State statutes for independent plans as such. The trend is toward the first-mentioned alternative, as statutes are amended to make broad-membership and professional-sponsorship requirements less mandatory. It is important that obstacles to this trend be removed. Where these plans are non-profit since they deal with service, it is logical that they be considered under prepayment, as opposed to insurance regulatory authority. Statutes should be changed that have been interpreted as prohibiting the formation of consumer-oriented independent plans, by adverse court decisions or attorney-general rulings, leaning on the rule against the corporate practice of medicine. There should be no artificial impediment to various organizational forms that are sought in the public interest. The American Medical Association has helped clear the way by its modification of the "free choice" principle, acknowledging that free choice now includes free choice of physician and free choice of medical-care plan.

In regard to regulation, the following steps are recommended:

1. Carrier associations should be strengthened for the purpose of improving the professional performance of carriers. More education and research are needed to provide a firmer fact base and to make

certain minimum standards or prototype procedures more widely acceptable.

2. Although made with the best of intentions, voluntary efforts are not enough. The public also needs protection through carefully designed and freely debated State regulatory authority. State laws vary considerably in their regulatory effectiveness. There should be clear-cut regulation and greater consistency among States, in the following areas at least:

- review of solvency;
- control of misleading or fraudulent representations;
- model contract language;
- filing and review of rates for all carriers: attention should be given to excessively low as well as high rates;
- a clear stipulation of minimum benefits: policies below a certain level of subscriber worth should be prohibited;
- stipulation that the regulatory authority can rule against unreasonable retentions;
- permissiveness in the definition of what constitutes a group for enrollment purposes: every effort must be made to overcome the limitations of individual coverage;
- sound cancellation laws to prevent carrier cancellation for reasons related to health: the subscriber needs as much protection as possible against any form of arbitrary action;
- conversion: all subscribers should have right to convert, without establishing insurability, from group to individual and from family to individual coverage or vice versa, with special rights of continuance to dependents upon the death of the subscriber.

3. Every effort should be made to remove the limitations on charters of carriers that prohibit their expansion into all legitimate areas of health care. Fragmentation is heightened when carriers have to specialize.

4. Every effort should be made to remove legal barriers against group practice or community ownership of prepayment. If necessary, specific legislative authority for either or both should be sought.

5. Some further regulatory provisions to protect small- and medium-group coverage and individual coverage should be explored. Provisions should be made for the pooling of smaller groups to even out widely varying loss ratios and for the charging of a class rate.

6. Stepped-up regulatory activity will take more manpower and funds. Many State insurance department offices are understaffed. With so much service and money at stake, budgets should be increased.

7. A major question is what to do about the wide range of State requirements, which makes it difficult for some carriers to use uniform policies and rates on a countrywide basis, and increases operating costs. Most importantly, some regulation is so patently submarginal and so politically dominated that it is difficult for the more conscientious States to protect themselves. These problems increase with growing population mobility. A study is needed to examine the feasibility of establishing minimum standards among States.

Other Consumer Protection

Better professional standards, as formulated by carriers, and stronger Government regulation will help the consumer to shop for coverage more intelligently. However, these cannot go far enough. Steps should be taken to reduce the number of health-service carriers and the number of benefit coverages on the market. The consumer is often confronted with a bewildering array of policies and rate structures that are difficult to evaluate. The companies do too little to shed light on the variety of facts that the consumer needs in order to make intelligent decisions. There are too many marginal companies in the business; the small operator cannot do justice to his responsibilities. Perhaps the ultimate in stronger licensure and regulatory provisions lies in the principle of franchisement; in some quarters this is put in the context of a public-utility concept.

It is recommended that, in each State, a consumer's panel be set up, supported by funds from industry, labor, providers of care, foundations, and others. This panel should employ a small staff that would list the companies operating in the State and give their major operating characteristics. Criteria of effectiveness should be worked out, bearing on retentions, control activity, reliability, etc., and these should be reported. Also, the comments by the panel on prototype policies—their strengths and weaknesses—should be made available to the public.

The myriad of companies and policies available will make the task difficult, and yet the myriad itself is one part of the problem of voluntary financing from the consumer's point of view. Some sort of consumer guidance should help to screen out the less worthy policies and companies.

Initial focus should be on individual coverage, although service to small groups may ultimately become feasible. The concept of a seal of approval is not without reason.

Individual Tax Relief

If corporations are given tax relief for the payment of health-insurance premiums as a matter of taxing policy, it would seem consistent to encourage individuals to purchase coverage through a tax incentive, particularly if safeguards, such as those mentioned, are established against poor or inadequate protection. With sounder regulation, more aggressive professional standards, and alert consumer review, the Government could feel more secure about the type of provision individuals would make for themselves. Currently, the individual taxpayer receives a deduction for medical expenses beyond a certain percentage of his income. The thrust should be toward purchase of

coverage, i.e., the avoidance of an excess of uncovered medical expenses. Beginning in 1967, a taxpayer who itemizes his Federal income-tax deductions may deduct one-half of his health premiums, up to a maximum deduction of \$150.

It is recommended that the above maximum be increased to \$300, with a higher allowance for families than for single persons.

The Role of Intermediary

The role of intermediary for carriers is widespread under Medicare and Medicaid. The concept had been pioneered under other Federal programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and, at the State level, under various welfare programs. It was put to a major test, under Medicare particularly, and has proven to be an effective service to the beneficiaries, the Government, and the providers of care. The role deserves and is getting the full support of the carriers. Through the concept, the Government maintains its basic responsibility and authority for the program, but is able to capitalize on the skills, equipment, programs, and techniques of established carriers, who are, in turn, able to work effectively with the public and the providers of care and reflect the many nuances existent at the local level.

Many steps have been taken to improve and clarify the mutual roles of Government, intermediary, and provider as the various programs have evolved. Testimony before the Congress by all three of these parties has put each on record in regard to further improvements.

It is recommended that, beyond the above, consideration be given to a fixed-fee contract between the Government and the intermediary, instead of the cost contract now existing, to pay the intermediary on a predetermined basis for administrative expense. This would save the cost of what seems to be interminable auditing and quibbling over proper expenses, and it would give the intermediary an incentive to perform.

Summary

This paper started by stressing the pluralistic nature of providing and financing health services in this country. A series of recommendations is proposed that, in effect, would narrow the scope of this pluralism. The most favorable degree of change is difficult to calculate.

On the one hand, there is the desirable goal of greater uniformity of performance so that all persons can enjoy adequate coverage with reasonable dignity. Clearly, this objective is difficult to fault. On the other hand, there are many questions about the best methods of achieving this objective. Here, there is less consensus. A variegated system has proven relatively effective up to this time in terms of its sensitivity

to local as well as national values and practices; it has been innovative, although not always continuously, and, importantly, it has generated prodigious funds for health services.

Under our pluralistic approach, some carriers and providers have experimented with and implemented controls well beyond the efforts seen in most countries. The system has shown its weaknesses in overlapping and inconsistent performance among carriers, and unnecessary variation in coverage in different parts of the country and among different parts of the population.

At first unsophisticated about the need for Government programs to help the disadvantaged, carriers are now learning to work with Government. Envisaged in this paper is a system of financing health services in which those who are gainfully employed, or otherwise able to purchase protection, obtain coverage from private carriers, and those who lack sufficient purchasing power are assisted by Government, through social-insurance and welfare programs, contracting with private carriers for their services.

Perhaps the fundamental flaw is an excess of publicly unrewarding competition among carriers vis-a-vis largely uncompetitive producers of services. Health care is involved in what often seem to be contradictory values of access, dignity, innovation, variety, and uniformity. If these values are to be properly balanced, the remedy lies in stronger internal and external disciplines for the entire industry.

Hopefully, this can be done. The present system of health services is viable. Many talented young men aspire to it. Our challenge is to trade some of its variety for greater productivity—to maintain its vigor while improving its management.

4

How Prepayment and Insurance Carriers Can Participate in Prepaid Group Practice

FOR SEVERAL DECADES, group practice and prepayment have been advocated as a logical and desirable way of arranging and paying for medical care. It seemed evident that the cumulating complexities of medicine would require physicians and other practitioners to combine their efforts. It seemed inevitable that care would not only be better organized but also made more accessible to populations through pre-arranged and pooled financing. Authorities studying the state of medicine in America, from the Committee on the Costs of Medical Care onward, endorsed group-practice prepayment so emphatically and repeatedly that it appeared destined to become a major mode of medical-care organization.

Instead, as the years proceeded, a different course was followed. Group-practice prepayment grew extremely slowly, achieved only modest dimensions, and operated in isolation from the main currents of medical affairs. Only now have its achievements in insuring more comprehensive care of acknowledged quality, especially in containing cost, placed group-practice prepayment prominently on the national agenda.

After a slow start, physicians are now actively coalescing into groups. Groups are forming, however, with little commitment to serve a defined population, without a direct association with prepay-

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ment, and without many of the expected benefits to physicians and patients.

Prepayment and insurance have grown phenomenally and, together with Medicare and other new programs of financing, are now approaching universality. For the most part, however, they have developed without reference to group practice, covering groups only incidentally and dealing with them by means largely unsuited to their operation.

Each of these three salients has been hurt by its separation from the others. Each has been addressed to only a portion of a much larger problem. The isolation of group-practice prepayment has greatly limited its opportunity to bring its benefits to the people. The separation of group practice from prepayment has been detrimental to its development. The severing of the mainstream of prepayment from its group-practice component has deprived the prevalent plans of participation in some of the most important and successful innovations in their field.

Some convergence of these still largely separate activities is increasingly necessary. It could set off the next major phase in the development of medical care in the United States.

Growth of Group Practice

Group practice is now growing exponentially. In the 13 years prior to 1959, the number of groups and of doctors had tripled.¹ The number of groups almost tripled again, between 1959 and 1966, when groups replying to successive surveys increased from 1,547 to 4,287. The number of physicians serving on their staffs roughly doubled in those seven years, increasing from 12,620 full-time and 1,389 part-time doctors to 25,449 and 2,971, respectively. The percentage of all physicians in private practice engaged in group practice increased from 8 to 15.6.²

The full extent and growth of physicians actually functioning in groups is probably even greater. Full-time hospital staffs acting as medical groups are not reported in the surveys. A large amount of informal grouping is also occurring—"group practice a la carte," as it has been called—which in total volume "probably exceeds that of organized group practice by full-time and part-time clinics throughout the country."³ The potential for continuing growth of group

¹ G. Halsey Hunt and Marcus S. Goldstein, *Medical Group Practice in the United States*, PHS Publication No. 77 (Washington: U.S. Government Printing Office, 1951), p. 49; U.S. Public Health Service, *Medical Groups in the United States, 1959*, PHS Publication No. 1063 (Washington: GPO, 1963), pp. 11, 12.

² *Group Practice: Guidelines to Forming or Joining a Medical Group*, American Association of Medical Clinics (Charlottesville, Va.), American Medical Association, and Medical Group Management Association, Second Revision, 1967, p. 7.

³ C. Rufus Rorem, "Medical Group Practice, Patterns and Problems," *Readings in Medical Care*, (Chapel Hill: University of North Carolina Press, 1958), p. 335.

practice is very great. It is widely accepted by patients. Notwithstanding lingering reservations and problems, it is broadly embraced by physicians, especially those now entering practice, many of whom no longer want to practice by themselves.

Groups Without Prepayment

Groups are thus developing rapidly. Many of the services they provide are covered by some prepayment or insurance. The payments, however, are based on the characteristics of solo practice, and the insurance is generally less comprehensive than the services provided by the groups. The fees may produce a windfall for some services but fail to cover others. This may disrupt the group by provoking the dissatisfaction of members who bring in more money. There is an essential disharmony between the basis of the insurance income to the group and the way it operates and pays its physicians. Although groups unaffiliated with prepayment may achieve some economies of scale, the results may not be appreciably more economical for the patient.

Some groups desire a more suitable basis for prepayment but have generally been unable to obtain it. Insurers have tried to cooperate, but the groups are generally too small to carry through their end of the explorations, and the companies have not seen promising enough prospects to make the necessary changes in their policies and practices. Setting up prepayment plans of their own has occasionally been considered and attempted by groups, but success is often precluded by their small size and lack of resources.

A small minority of existing groups are affiliated with prepayment plans. Only 129 of the 1,228 multispecialty and general-practice groups in 1959 were directly involved in prepayment.⁴ Accordingly, the rapid growth of group practice has not been accompanied by the development of a suitable form of prepayment, and many of the potential advantages of group-practice prepayment have been lost.

Group-Practice Prepayment

Those seeking the advantages of group-practice prepayment have generally had to create whole new plans. Such plans have become a direct expression of the desires of consumers, cooperatives, industry, labor, and communities concerned with obtaining care for a constituency. These groups have brought their aspirations—for service, for prevention of illness, for comprehensive and continuous care, and for other features—to group-practice prepayment, and they have animated and enriched its development.

⁴ U.S. Public Health Service, op. cit., p. 83.

By and large, such plans "have not grown substantially."⁵ In 1964 there were 196 plans, involving some 4,143 full-time and 5,843 part-time doctors and covering some 4,048,000 people.⁶ But their capacity to grow is vividly demonstrated by the Kaiser Foundation Health Plan, whose membership nearly doubled from 881,000 in 1961 to 1.5 million in 1965. Even when enrollment is closed for saturation of facilities, its membership continues to grow by 8 to 10 percent a year.

Group-practice-prepayment plans are often regarded, even by themselves—through an afterimage acquired during their formative period—as a controversial and radical innovation. For at least a decade, however, they have operated in a decidedly different climate and have assumed an equally different character.

The legal and ethical basis for such plans is established and generally accepted. Many—though by no means all—of the restrictive laws that previously prevented such plans from forming or operating have been eliminated by the legislatures, overturned by the courts, or ignored by interpretation. Criticism of contract medicine has virtually disappeared and charges of corporate practice have diminished. Objections to "closed panel" practice have been directly overcome by providing for voluntary enrollment in many of the plans through dual- or multiple-choice elections, in which every family chooses whether to receive its care from a group or from individual practitioners. Although an aura of controversy remains and some opposition persists, group-practice prepayment is an accepted type of medical organization. It is not a "far out" form of medical care today. Indeed, it does not represent the last word in medical engineering, and is actually quite conventional in its doctor-patient dealings. For several years, the plans have directed their energies to solving their internal problems and improving the structure and functioning of their medical groups. They now present a fairly well-refined system of arranging and paying for care.

QUALITY OF CARE

The quality of care under group-practice prepayment is at least as good as that generally available in the communities in which the plans operate. The most comprehensive assessment and acknowledgment of the quality of their service is still that made by the American Medical Association's Commission on Medical Care Plans. The Com-

⁵ Louis S. Reed, Arne H. Anderson, and Ruth S. Hanft, *Independent Health Insurance Plans in the United States, 1965 Survey*, Social Security Administration Research Report No. 17 (Washington: U.S. Government Printing Office, 1966), p. 64.

⁶ William A. MacColl, *Group Practice & Prepayment of Medical Care* (Washington, D.C.: Public Affairs Press, 1966).

mission, in 1956 and 1957, visited "miscellaneous" plans with a total enrollment of 2,654,100 people, including representative group-practice plans. Special heed was paid to the quality of care, and criteria were developed for judging it. The Commission concluded that "good medical care is being provided, within the scope of services offered, by the units (of the plans) visited. . . . The professional training of physicians who provide services in the plans visited appears to compare favorably with that of other physicians in the community. On the whole, physicians serving these plans appear to have sufficient time to care for patients. . . . The technical equipment and physical facilities . . . appear to be satisfactory for the types of services rendered." ⁷ These conclusions provide a reliable reading of the general character and quality of the care rendered. Other studies corroborate these findings.

The group-practice plans provide an institutional framework that favors good care. The mode of practice exposes the doctor much more fully to the judgment of his peers. Quality assessment is extended beyond the hospital into the clinic, where most services are rendered; this alone is a great advance. Some plans have made arrangements to study and audit the quality of the care rendered and, indeed, have contributed to quality-assaying methodology.⁸ Future studies of quality may well demonstrate the superior quality of group care. For the present, it is clear that the benefit and cost advantages of group-practice prepayment are not achieved at the expense of the quality of the care its physicians render.

COMPREHENSIVENESS OF CARE

Group-practice-prepayment plans provide considerably more comprehensive protection than is generally available.⁹ This was evident a decade ago when the AMA's Commission on Medical Care Plans concluded:

"The benefits provided through various miscellaneous and unclassified plans are broader and more comprehensive than those provided through most other prepayment mechanisms." ¹⁰

The principal advance toward comprehensiveness of protection has been in ambulatory care, including physicians' services in clinics and

⁷ "Report of the Commission on Medical Care Plans," Part 1, "Findings, Conclusions and Recommendations," *Journal of the American Medical Association*, Special edition, Jan. 17, 1959, p. 49.

⁸ Sam Shapiro, "End Result Measurements of Quality of Medical Care," *Milbank Memorial Fund Quarterly*, XLV (April 1967), part 1, pp. 7-40.

⁹ A few plans, however, use group practice and prepayment but do not aspire to provide comprehensive care. These offer, for example, some single service, such as dentistry.

¹⁰ Loc. cit., p. 48.

health centers and X-ray and laboratory examinations. These benefits are often excluded entirely in standard plans or covered only to the extent that the expenses survive a sometime substantial deductible provision. The typical prepayment and insurance plan has not nearly caught up with group-practice prepayment in coverage of physicians' services. Independent plans spend much more for doctor care. Their benefit expenditures for this purpose, per person enrolled, averaged \$31.34 in 1965, compared with only \$18.62 spent by Blue Cross and Blue Shield plans and \$14.59 by insurance companies.¹¹ The money they spend for physicians' services probably goes further, so that there is an added advantage to the subscribing public.

The broader coverage of physician care is addressed in part to diagnostic and preventive services—a distinctive feature and aim of these plans. In this and other benefits as well, the availability of a medical staff directly employed by or closely affiliated with the plan permits benefits to be designed, administered, and controlled, and thus extended more confidently than under conventional prepayment and insurance arrangements. The Group Health Cooperative of Puget Sound, for example, has gone the furthest in providing all prescribed drugs in full under prepayment.¹² The plan relies on the close cooperation of the medical staff and resorts to a formulary, volume-buying, and supervision by a pharmacist.¹³ The group-practice plans have not gone as far in benefit development as their organizational advantages would permit. However, they have started with broader benefits and are better able to expand them further.

CONTAINING AND CONTROLLING COST

With care of at least comparable quality and benefits that are generally more comprehensive, group-practice prepayment is demonstrating an ability to control costs unmatched by other plans. At a time when the rising costs of health care are assuming critical importance, this feature of group-practice prepayment is propelling it into acute national prominence and can be decisive in enlisting much greater support for its extension.

The overall cost of health care to subscribers of group practice is demonstrably less than under typical insurance plans. A comparison is available of the total costs of care, the prepayment premiums, and the out-of-pocket expenditures by California State employees and their families under the Kaiser and Ross-Loos group-practice plans and under other representative plans in 1962-63. The premiums of the Kaiser plan were virtually indetical to those of Blue Cross and Blue

¹¹ Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1965," *Social Security Bulletin*, XXIX (November 1966), p. 10.

¹² Reed, Anderson, Hanft, op. cit., p. 55.

¹³ MacColl, op. cit., p. 72.

Shield. But the total cost of health services (excluding dental care, eyeglasses, and nonprescription drugs) for families of four was \$112 a year less.¹⁴

The comparison was as follows :

Plan	Total cost of stated services	Prepayment or premium cost	Out-of-pocket cost
Kaiser.....	\$373	\$284	\$89
Ross-Loos.....	396	271	125
Blue Cross-Blue Shield.....	485	285	200
Insurance.....	416	227	189
Foundation.....	473	308	165

The total cost of health care was at least one-tenth and up to one-fourth less under the Kaiser plan than under the non-group-practice plans. It benefits covered the highest percentage of total costs; its members paid the least out of pocket.

Group-practice-prepayment plans characteristically experience markedly less utilization of inpatient services. The utilization rate for nonmaternity hospitalization under the Federal Employees Health Benefits Program in the contract term ended December 31, 1965, was 415 days per 1,000 members, compared with 924 days for Blue Cross-Blue Shield subscribers, and 945 days for those covered by insurance companies.¹⁵

The differences are partly due to different age and other characteristics of the population at risk. However, within comparable age groupings, the rates for group-practice-plan members remain much lower.¹⁶

A more exact assessment of the reasons might reduce some of the differences but not enough to invalidate the basic conclusions. Group-practice prepayment greatly reduces the volume of hospitalization without depriving patients of the care they need. It makes available broad ambulatory care, which substitutes a more desirable and desired form of care. It reverses the incentives that stimulate hospitalization under the usual benefit design and, instead, motivates the doctors to control hospital utilization.

¹⁴ Malcolm Watts, S. M., M.D., et al, *A Special Report of the Medical and Hospital Advisory Committee to the Board of Administration of the State Employees' Retirement System*, Sacramento, June 1964.

¹⁵ George S. Perrott and Jean C. Chase, "The Federal Employees Health Benefits Program, Fifth-Term Coverage and Hospital Utilization," *Group Health and Welfare News, Special Supplement*, May 1967.

¹⁶ George S. Perrott, "Federal Employees Health Benefits Program, Utilization of Hospital Services," *American Journal of Public Health*, LVI (January 1966), 57-64. Rates for Federal employees and annuitants under group practice and Blue Cross-Blue Shield plans in the contract year ended Oct. 31, 1962, are shown below :

Age	Hospital days per 1,000 members	
	Group practice	Blue Cross
19-34.....	345	549
35-44.....	464	854
45-54.....	756	1, 237
55-64.....	1, 247	1, 880
65 and over.....	1, 256	2, 320

Along with reduction in hospitalization, markedly fewer surgical procedures are performed by the physicians under group-practice prepayment, both in the aggregate and for such often questionable procedures as tonsillectomies, appendectomies, and "female surgery." The rates, again emanating from the Federal employees' program, are cited below:

Procedure	Rate per 1,000 members	
	Group practice	Blue Shield
All procedures-----	39	70
Tonsillectomy and/or adenoidectomy-----	4. 0	10. 6
Female surgery ¹ -----	5. 4	8. 2
Appendectomy-----	1. 4	2. 6

¹ Mastectomy, hysterectomy, and dilatation and curettage, nonmaternal.

Source: G. S. Perrott, "Utilization of Health Services," *American Journal of Public Health*, LVI (January 1966), 62-3.

Members of such plans as Kaiser and HIP ¹⁷ see physicians about as often as the general populations in their areas. The plans, however, are able to schedule doctor-patient contacts more effectively than in solo practice. For these and other reasons, the group-practice plans are able to save money on physician costs. These savings are not effected by substituting other personnel for physicians. On the contrary, the group-practice physicians have, to a fault, tended to follow a conventional mode of practice. Conceivably, further economies could, and perhaps should, be made through improvements in the use of manpower.

Group-practice prepayment thus holds a vast cost advantage over other prepayment and insurance plans. Understandably, the recent Report to the President on Medical Care Prices urged: "Group practice, especially prepaid group practice, should be encouraged." ¹⁸

New Influences

In addition to such endorsements, many new currents and influences support the further development of group-practice prepayment.

MULTIPLE CHOICE OF PLANS

Increasingly, those who purchase health insurance wish to give their beneficiaries the opportunity to join group-practice plans if they so desire. Employers and health and welfare plans who would not require their employees or members to receive care from a designated source want them to have a choice of plan. Dual choice has been in-

¹⁷ Health Insurance Plan of Greater New York.

¹⁸ U.S. Department of Health, Education, and Welfare, *A Report to the President on Medical Care Prices* (Washington: U.S. Government Printing Office, 1967), p. 4.

creasingly adopted by benefit plans and accepted by the medical profession as a form of free choice of physician.¹⁹ Industrial concerns now obligated to pay for an increasing share of the costs of medical care through their benefit plans are concerned with the rising costs of care. Some are not impressed with the efficiency of medical practice and welcome steps that might improve its organization and efficiency, in line with contemporary capabilities and practices in other fields.

Dual choice has brought group-practice prepayment into the mainstream of health and welfare activity. It has given group practice an additional chance to grow. Nearly 45 percent of the Federal employees in the Los Angeles area have chosen the group-practice plans (Kaiser and Ross-Loos). It has given much greater visibility to group-practice prepayment by providing a public forum for the comparison of plans. It has also provided controlled conditions for comparing the rates and the reasons for rejection as well as acceptance—to determine why, for example, as few as 2.5 percent of the Federal employees in certain regions have chosen the group-practice offerings. It has highlighted the geographic limitations of locally based plans. It has illuminated the desires of many subscribers to retain their choice of physician. It has revealed significant benefit gaps in some group-practice plans.²⁰

PUBLIC POLICY

Multiple choice is now further extended under Medicare. Although this new program concentrated on the customary arrangements for both providing and financing care, it permitted the participation of group-practice-prepayment plans. It has set what could be a powerful precedent, whereby a single health insurance plan offers solo and group practice simultaneously and reimburses each on a different basis. (Significantly, in looking for ways to build incentives for lowering costs into Medicare, the House Ways and Means Committee has proposed revisions that would permit group-practice-prepayment plans to combine reimbursement of hospital and physician services.)

Medicaid, as well, though itself not an insurance program, may also resort to group-practice prepayment. The Report to the President on Medical Care Prices urged the Government to encourage group-practice-prepayment plans by amending Title XIX²¹ of the Social

¹⁹ The California Medical Association declared in a set of basic principles that "everyone is entitled to his free choice of medical plans" (*CMA Newsletter*, II [September 1957]). This principle has since been accepted by medical societies in other areas, and the AMA Commission on Medical Care Plans reiterated and reinforced it in a national context.

²⁰ Marie B. Henderson, "Federal Employees Health Benefits Program, Role of the Group Practice Prepayment Plans," *American Journal of Public Health*, LVI (January 1966), 55.

²¹ "Grants to States for Medical Assistance Programs."

Security Act. The amendment would require States to allow Medicaid recipients to use such plans and would encourage the States to use Medicaid funds to foster and extend the group practice of medicine.²²

INTEREST AND INVOLVEMENT OF ACADEMIC MEDICINE

Programs now under development at several leading medical schools could extend group practice and prepayment. This should not be surprising, as group practice probably originated in the outpatient departments of medical-school-affiliated hospitals. Medical colleges have arrived at a consensus that they need to train doctors not only in the traditional paths but in the fuller application of medical knowledge; they have concluded that "schools of medicine should be taking the lead in studying the ways medical care is delivered to patients."²³ They are planning programs in which health care can be studied, experimented with, and taught, and improved methods and systems of health care can be devised.

Medical educators are not primarily seeking to vindicate or promote group-practice prepayment. They want foremost to extend and improve the education of physicians and to improve practice in all its forms. But to study health care with a representative population they need to acquire ties with prepayment and insurance. And to improve the delivery of care they must consider group practice along with other forms of organization and other methods of improving service. Some schools will wish to affiliate with group-practice-prepayment plans where they now exist. Some may form new plans of their own. Some may encourage and aid community groups in forming such programs and work with them. Some may look for associations with the prevalent prepayment and insurance plans.

In seeking to improve the organization of care they will pay "specific attention . . . to the organization and methods of group clinic practice." Indicative of their thinking is the following statement of aims: "Means of making hospital-centered practice fully effective need to be considered. . . . Means of making the team approach to the practice of medicine fully effective need to be perfected. . . . Universities . . . should set up models to demonstrate how the team approach can be made most effective in the group practice clinic environment."²⁴

Several medical schools are currently planning to examine new uses of manpower, new applications of technology, and programs that will, in fact, not merely adopt aspects of group-practice prepayment but

²² Op. cit., p. 5.

²³ Lowell T. Coggeshall, *Planning for Medical Progress Through Education* (Evanston: Association of American Medical Colleges, April 1965), p. 38.

²⁴ Ibid.

probably alter it in the process. Medical schools will bring new resources to the improvement of the organization of care. They will enlist medical educators and leaders of great prestige and accomplishment and involve hospitals of greatest distinction. They will attract young physicians of excellent training into the field. They will attach new intellectual interest to the problems of improving the delivery of the medical knowledge they generate and transmit. They will not, however, divert large portions of their program to mass medicine or convert the teaching hospitals into neighborhood health centers. Faculties of medicine will build models for care; for large-scale applications it will be necessary to look to the community's medical and fiscal resources.

PROSPECTS FOR FURTHER GROWTH

There is thus an accumulating and accelerating acceptance of group-practice prepayment. New need, new interest, new sponsors, and new support all promise additional growth. It would be deceptive, however, to overstate the actual prospects for growth and fail to consider factors that may continue to limit group-practice prepayment to dimensions not nearly commensurate with its importance.

It has not acquired a form of organization that can sustain large-scale growth and operation. Most of the plans use group-practice prepayment to serve a confined constituency such as an employee or union group, and these have not grown appreciably. The great majority of the group-practice-prepayment plans have fewer than 5,000 subscribers; of the 196 plans reported for 1964, only 34 had as many as 25,000 subscribers. In most instances, moreover, the size of the plan rules out hospital-based prepayment. Their small size also limits their ability not only to market their coverage but even to operate with optimum efficiency. By and large, they have embraced group medicine but resorted to solo-practice forms of prepayment and insurance.

Thus, although group-practice prepayment is clearly bound to grow more than in the past, it is hard to visualize a vastly greater growth without some additional changes in organizational forms. One of the most promising of these would be to find ways by which the emerging group practices, the mass prepayment and insurance plans, and the existing group-practice-prepayment plans could cooperate.

What Prepayment and Insurance Carriers Can Do

The principal prepayment and insurance carriers face a choice among three essential policies: (1) They can continue with present forms of practice and payment and provide only incidental financing for groups. (2) They can support group practice along with solo

practice and provide suitable financing for each. (3) They can seek to encourage improvements in the organization of care in various ways.

If the carriers wish to support group practice or at least not hinder its development, three primary courses of action are open to them: (1) To facilitate dual and multiple choices among competing plans, (2) to join with group-practice-prepayment plans in marketing and other administrative services, and (3) to bring group-practice options into their own arrangements.

FACILITATE DUAL AND MULTIPLE CHOICES

Recognizing that dual-choice options are increasingly desired and that competition among plans is likely to prove beneficial, carriers can accommodate to dual-choice elections, make them a standard procedure, and cooperate with group-practice plans in facilitating and conducting them. People now insured would be given the option of joining group-practice-prepayment plans where they exist. Where some stipulated percentage of enrollment is required among the eligible persons, the percentage would be applied to those choosing both options. This is now occasionally done by carriers together with such plans as the Kaiser Foundation Health plans and the Health Insurance Plan of Greater New York. Such procedures would become more routine and more generally accepted. In time, the tide of enrollment would be determined by the performance and attractiveness of the alternatives rather than limitations imposed on the choice of plans.

PROVIDE FOR JOINT MARKETING AND ADMINISTRATIVE SERVICES

If the carriers wish to support group as well as solo practice, they can take various steps. Prepayment and insurance plans might make available certain services to group-practice-prepayment plans. They might provide marketing, enrollment, and some administrative services. Joint marketing would make available the choice of group-practice prepayment to a still wider population. The sales organization would not be confined to a single product but would present multiple plans. This would mainly be an extension of the cooperative arrangements now often undertaken by Blue Cross and Blue Shield plans or between such plans and some newly formed dental-service organization. It would be an extension of the joint administration of different plans under Medicare, under which private carriers have assumed new functions.

BRING GROUP-PRACTICE OPTIONS INTO THEIR OWN ARRANGEMENTS

Beyond sharing services, some carriers may wish to offer group- as well as solo-practice options to their own subscribers and policy-

holders. This would involve the same carrier in both options and thereby maintain or increase the enrollment of the present carriers—overcoming one limitation of other alternatives considered thus far.

Specifically, any prepayment or insurance plans could, in cooperation with one or more medical groups, develop a suitable schedule of benefits to be prepaid or insured. The plan would offer to subscribers the option of receiving their care from a group. It would collect an appropriate premium and reimburse the group for those subscribers who enrolled with it. Appropriate methods of reimbursement would be determined. This would provide broad benefits and group medicine for those who desired them. It would put the group physicians in parity with solo practitioners and support both forms of practice and payment. It would enable group practices to participate in a form of payment consonant with their operations and need. It would provide access to group-practice prepayment to a larger population.

The carrier could, in addition, arrange for benefits when services were required outside the area where the group is located and thus overcome one disadvantage of such local arrangements.

Instead of committing the insuring mechanism to one form of practice, the same carrier could support medical practice in all its principal forms. Instead of being committed to paying the physicians solely on a fee-for-service basis, the carriers—as Medicare has done—could make reasonable payments on other bases. Prepayment and insurance would thus assume a less partisan role in that they would not be taking sides against one or another mode of practice or method of payment. They would offer essentially equitable support to all ethical variations in practice and in payment.

Some of the existing group-practice-prepayment plans might wish to avail themselves of similar arrangements. There could be a division of labor whereby the group-practice organization would concentrate on the development and management of medical groups while the prepayment or insurance carriers would provide financial and management aid.

As many existing medical groups would remain too small in size, medical groups, medical schools, and community or consumer bodies could, in cooperation with the carriers, form locally based organizations devoted to making arrangements with hospitals, physicians, and other health professions, and receiving and distributing funds.

Conceivably, some carriers may wish to assume a still more active role in encouraging positive improvement in the organization of the health services they help finance. If a small portion of the premiums devoted to the purchase of health services could be assigned by the carriers for developmental purposes, to compile information, to offer voluntary assistance to solo and group practitioners, and to encourage

and support experimentation in medical-care organization, the private sector of health care and its financing could be greatly strengthened. Carriers could provide, for the solo and group practitioner, some of the managerial support that the Kaiser industrial organization has provided in its health plan with such evident success. Very little developmental work is occurring in this field, and much or most of it is now publicly financed.

Carriers could also provide loans for the construction of group-practice facilities and help overcome one of the obstacles to the improvement of medical organization, again bringing private support to a field that has increasingly had to turn to Government.

How the carriers respond to these ideas will depend on their perceptions of the present state of health insurance and of their future roles. Health insurance is entering a new stage in its development. More than likely, insurers will have to assume some new responsibilities for the availability, the cost, and the quality of the services they finance. They will become more involved in consideration of the organization of care. What is explored here is essentially an extension of their present activities in line with the development of voluntary insurance and its basic principles. Subscribers could choose the kind of plan they wanted and whether to receive care from a single physician or a group. Physicians could choose one or another mode of practice. Carriers would make available a variety of benefits and arrangements. It would not be necessary for them to abandon or even disrupt their present arrangements with the predominant forms of practice and payment. Rather, they would no longer be devoted exclusively to them.

Characteristically, we in America are not likely to have a single system in such matters. There probably will be group and solo practice, fee for service, and capitation. However, these should exist in proportions determined by their acceptance, each approached voluntarily and given the opportunity to perform and be judged by its works. There is perhaps no better way of strengthening the private sector of health care than to provide at least some support to the next major step in the evolution of our health services—the strengthening of their organization.

Wilbur J. Cohen

5

Next Steps for Voluntary Health Insurance

THIS CONFERENCE may well become a landmark in the development of health insurance. It could open a new era in cooperation between the private and public sectors in health insurance. It could be the point where creative ideas that we all have been thinking about for some time are actually translated into a commitment to actions that will assure more effective and economical ways to finance the best health care that medical science and professional skill can provide for all Americans. The knowledge, the experience, and the expertise are here.

The conference, I believe, has been extremely helpful for all of us. But it is only a beginning. It would be inexcusable if we were all to leave here today without agreeing to turn creative ideas into concrete actions. The Department of Health, Education, and Welfare asks each major group here today to report back within the next few months the plans of action their organizations are undertaking and their recommendations for further steps. We realize that it will take time to set forth these plans, but as you work them out with your colleagues and go forward with them, no doubt you will have further ideas and valuable suggestions to report.

For a day and a half now, you, who represent leadership in insurance, medical and hospital professions, labor, management, and State governments, have come to grips with the challenges calling for new

WILBUR J. COHEN, Secretary of Health, Education, and Welfare, was formerly Under Secretary. On leave as professor of public welfare administration, University of Michigan, he has been intimately connected with all the legislative developments in the social security and public assistance programs since 1934 and was closely associated with the recent Medicare, medical-school, and education legislation.

patterns of coverage, financing, and prepayment for health care. In frank and candid discussion, you have admitted shortcomings and at the same time germinated new ideas. You have shown a willingness to experiment and to work together for increased effectiveness. As national leaders in your fields and as top policymakers of your own organizations, we are confident that you will be able to stimulate new directions in health insurance *practices* as well as *ideas*. That is why the Department is very interested in receiving the reports of your progress.

GROWING AWARENESS OF THE PUBLIC

Rapidly rising costs of medical care and the financial barriers to meeting these costs are of growing concern to the people of this Nation. There is increased recognition of the importance of high-quality health care, with services where the individual needs them, when he needs them, and at a reasonable price.

Aside from the requirements of specific segments of the population, health insurance has gone a long way toward providing coverage on a voluntary basis. The record speaks for itself. Yet at the same time, the record shows gaps and fragmentation, as well as overlaps, in coverage.

It has been amply demonstrated that health insurance has exerted a strong force in molding the health system that exists today. Some have implied that it has warped the system through a concentration on coverage of short-term inpatient hospital care and that this has increased cost to substantially over what it would have cost to offer alternatives to hospital care. It is generally acknowledged that there are pressures on physicians to admit patients to hospitals when short-term care as a bed patient is the only benefit provided under health insurance coverage.

OTHER AVENUES TO COMPREHENSIVE HEALTH SERVICES

The public has a heightened awareness that there are other avenues to health services than the route that leads directly to the hospital bed. The Medicare program is making it evident to the American people that there are many levels of care designed to provide continuity without the expense of a hospital stay. The whole spectrum of physicians' offices, group-practice clinics, hospital outpatient services, extended care, and home care is gaining recognition and acceptance. There is the beginning of an articulate demand by the public for these services—partly as an expression of concern over high costs and partly out of a desire to be assured the kind of care the individual needs, rather than be forced into the old accepted pattern of hospitalization.

In my opinion the user wants alternatives. People do not necessarily demand inpatient hospital care for illness. They accept it only if it is the sole route to paid benefits. If he is paid for outpatient care, or for doctors' services in an office or in a clinic, the patient is happy. He wants his insurance to cover the bill.

The advent of Medicare has brought forcibly to the American public the fact that many services besides acute bed care are available and that they are effective in treating illness. An important fact is that these services are available to an insured patient—not just to the medically indigent. Families of Medicare patients, who can observe the value of these extensions to hospital service, want them also. And this demand is building.

ROLE OF PRIVATE INSURANCE

Private insurance will have to do several things to meet the public's demands. I am continually being asked if I think Medicare will be extended to persons under age 65. My answer is if, in the opinion of the public, private health insurance "does the job," if it "works," if private insurance is able to provide adequate protection for high-quality care to 90 to 95 percent of that population at the prices they can afford—then little public pressure will develop to extend Medicare to those under 65 who are employed.

Will private health insurance be able to do this job adequately? That will depend on several factors.

First, medical costs will be a decisive factor. If medical-care costs continue to soar, then private insurance will have difficulty providing adequate coverage and protection at a price the public can afford. We all share in this tremendous responsibility of moderating medical costs.

Second, ways will have to be found to extend protection to the 15 to 20 percent of the population under age 65 who are not now covered by health insurance. The ability of private insurers to extend their programs to small groups and small businesses at rates they can afford will be an important factor in the future direction of who provides health-insurance protection. A way must be found to make coverage available to employees of small firms, farm employees and farm managers, private household workers, and the unemployed. Private insurers could, for example, support extension of Medicare to the permanently disabled under age 65.

Private insurers must find a way of reducing the large proportion of health and medical expenditures that are not met through insurance. In 1965, insurance covered only about one-third of all consumer expenditures for medical care. About three-quarters of the cost of hospital

care and about a third of physicians' services were paid by health insurance. Treatment of mental illness, outpatient services, home nursing care, dental care, prescription drugs, and private-duty nursing are often excluded. Health insurance should be covering somewhere in the neighborhood of 90 percent of all consumer expenditures for health care.

Improvements in private health-insurance protection would limit the need for expansion of Medicaid. Medicaid is a program designed to fill in the gaps in private insurance for low-income people. Actually, in 1963 about 40 percent of the poor had some form of hospital insurance. But the problem was how adequate was that protection?

The combination of rising levels of income and the decline in poverty that can be expected in the future will improve the opportunities for using the insurance mechanism to protect more people against the high costs of illness. Whereas in 1959 there were 40 million people who were poor, today there are about 30 million, and by 1968 I expect the number to be reduced to 25 million. As the number declines and more people are working, there will be less need for a Medicaid program if private insurance is made more widely available to the groups who are now inadequately protected. There is no reason why anyone who has a job in industry, irrespective of how much he makes, could not be provided with comprehensive health insurance. Employers and unions should cooperate in efforts to find ways to finance this coverage.

Improved coverage and protection will cost more. New ways of financing the cost of health insurance must be explored. Perhaps more flexible use of re-insurance arrangements should be explored. Increasing the employers' share of the cost of health insurance is also another possibility.

The survey of the Health Insurance Institute of new group policies issued in 1966 found that 46 percent of the employees involved had the cost of their coverage paid for entirely by their employer; about 54 percent had it partly paid. If this trend continues, private health insurance can continue to expand.

The health-insurance industry trend toward noncancelable health insurance policies is also encouraging. It should become a universal provision.

If private health insurance can provide adequate protection to enough persons at a reasonable cost, with assurance of access to high-quality care, little pressure for a public program will develop.

ROLE OF GOVERNMENT

Government has a legitimate involvement in health care. The health and well-being of a people is a nation's greatest asset for achievement

and even for survival. It is appropriate that Government continually assay the quality and quantity of health services and their distribution to assure the highest level of care for all Americans. And when the poor cannot afford health care, this, too, is a proper concern of the Federal Government, which must uphold the right to the best health care for all its citizens, considering medical need, regardless of age, sex, color, or any other factor. Government cannot abrogate this responsibility, but it can and must work as a partner with the private sector in achieving this goal, which is a mutual interest of both. One proper course for all third-party purchasers is an interest in, and an involvement in, the effectiveness of their providers.

CHALLENGES FOR TODAY AND FOR THE FUTURE

Basically, what is needed is health insurance that can provide health-care financing for services of high quality, which are, in turn, effectively and economically provided. Implicit here is a stronger role for health insurers in developing incentives for providers to increase their efficiency and effectiveness. Optimal use of facilities and services, as well as increased productivity, are key factors in moderating the rise of medical costs. Major purchasers should look to providers for accountability as to their efficiency and effectiveness if they are to exercise their stewardship over the public's dollars.

To meet the health needs of the public, private health insurance should cover all necessary health services for the diagnosis, therapeutic care, and prevention of illness. Gaps must be filled, such as the provision of treatment for mental illness, which is now scarcely touched in prepayment. Coverage for outpatient clinics, extended-care facilities (including nursing homes), home health services, and drugs should be available. The use of less expensive alternatives to acute short-term care can result in great mileage from the insured's dollars.

While under some conditions it may be desirable for patients to pay part of the cost of service directly, at the time of receiving care, the main means of assuring prudent and economical use of services should be appropriate utilization review and incentives. All health-insuring organizations share in the responsibility of assuring that funds expended through prepayment and insurance have the effect of increasing the efficiency and economy of health services without adversely affecting their quality. Activities that will help attain this goal include effective participation by carriers in State and areawide health planning, the development and use of standards of reasonable payment for services provided, and incentives for efficiency in reimbursement methods.

Government and private health insurers must work together in developing reimbursement principles and methods to assure this efficiency. We both have a big stake in the problem. Together, Government and private insurers can play a major role in controlling the cost and quality of medical care.

H.R. 12080, the Social Security Amendments of 1967, as passed by the House of Representatives, would give the Department of Health, Education, and Welfare authority to experiment with alternative methods of reimbursing hospitals or other providers of care which would provide incentives to help keep costs down while maintaining quality care. I would like to see this provision to experiment expanded to cover physicians' services.

Together, Government and private insurers can explore other bases of reimbursement which may through experimentation be demonstrated to be effective. Under the provisions of the House Bill, the Secretary would be required to report annually to the Congress on the experience in carrying out these experiments. We would gladly share with you this experience. But we would also be grateful for any knowledge you could share with us. We encourage you to engage in these experiments.

Another area in which Government and private insurers can cooperate is the support of health-planning activities being carried on in the States by public and private agencies.

Earlier this year the Administration proposed, in H.R. 5710, that when institutions participating in Medicare make capital expenditures that are not in accordance with Statewide health plans, the Department of Health, Education, and Welfare, would have authority to reduce the reimbursements to the institutions or to terminate the participation agreement with them. In my opinion there is no reason why Federal funds, or private health insurance funds for that matter, should be used in competitive drives to put expensive, highly specialized equipment and services in every hospital. Such a requirement as the Administration proposed can do much to strengthen State health planning and we shall continue to urge legislation along these lines, with such modifications as are necessary.

The proposed amendments would also allow the Secretary to make agreements with States to utilize the services of State agencies, normally those designated under the Partnership for Health Act, to determine whether capital expenditures are in accordance with the overall plan of the State agency. If expenditures are made that are not in accordance, there would be authority to appropriately reduce reimbursement to the facility making them or to terminate the participation agreement with the facility.

The proposal also provides that depreciation of plant and equipment will be included in "reasonable cost" only if a provider of services furnishes satisfactory assurance that it will (1) set aside and keep separate the amounts paid under Medicare for depreciation, and (2) not utilize the amounts for either capital or noncapital purposes except under conditions approved by State planning agencies. Similar provisions would be made under Medicaid. This proposal is intended to avoid having the Medicare program undercut State health planning measures.

Planning activities are already widespread, and 25 Blue Cross plans (in 16 States) have reported to us that they support these activities by including planning and/or depreciation funding provisions in their contract with their member hospitals. I would like to see more plans support these activities.

There is also great need for more internal research and collection and use of data pertaining to the role of health insurance in financing services. National organizations should publish full information on expenditures by insurance and prepayment plans for both health care and administration. Only the full, objective review of the financial experience of all health insurance organizations and of the expenditures being made for specified services can produce meaningful analyses of where the health care financing system is going. In this program the Federal government will share its data and experience, as a major third-party purchaser, with others in the field.

In cooperation with the health professions and other interested groups, private health insurance should develop methods which enable individual and group purchasers of health insurance to evaluate critically the relative merits of the competing packages which are marketed by the industry. At the present time, it is difficult if not downright impossible for most purchasers to make valid comparisons. The principle of caveat emptor needs to be displaced by a greater emphasis on clear, understandable, and factual descriptions of benefits provided.

You have noted in this conference that in some States there are legislative barriers to the development and operation of some insurance programs. States should give careful consideration to the removal of such barriers.

Discussions at this conference reflect the recognition that affirmative action must be taken by both the private and public sectors in health care. We are all agreed that the existing system of financing health care has shortcomings, but there is a determination to do something about them. Experiments will be needed. New patterns will have to be established. The Government is willing to do its share, with whatever support or assistance it can give.

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